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Trust and Gender in Patient-Practitioner Relationships

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Abstract

This research investigates the phenomenon of patient trust in primary health care providers. Using the qualitative methodology of Memory Work, this research draws largely on social constructionism to understand gendered ‘lived’ experiences of trust within the patient-practitioner relationship. The central question of this research, then, was: How do male and female patients describe and perceive their experience, both positive and negative, of trust in primary health care practitioners (PHCPs)?

Following the Memory Work method, two groups of participants, one comprising four men, the other five women, independently wrote detailed narratives of their lived experiences of trust. These experiences were evoked by agreed ‘trigger’ topics that each group felt explored and represented trust within the patient-practitioner relationship. The participants then came together as a group to discuss and analyse the individual narratives for the ‘common’ sense or the social aspects of the experiences common to the group, and the processes used to make sense of them. Both the women’s research group and the men’s research group met for five sessions, each session lasting at least three hours. Between them the research participants wrote 43 individual narratives (two absences) and generated more than 30 hours of recorded group work. From their written descriptions and verbal discussions of their individual narratives, this research describes and explains the trust that these participants experienced, and explores the meaning that these men and women themselves ascribe to trust in various health care service contexts. Specifically, Memory Work facilitated the participants’ own understanding of how their individual experiences of trust have been constructed by the self, and the social processes of gender on self.

This research worked at two levels of analysis and interpretation (textual and cross-sectional), examining the experiences both within and between the men and women in the study. A number of common themes were found to be critical to patient trust for these women and men showing important gender differences in how trust is lived and understood within the patient-practitioner relationship. The themes that the women use to make sense of their trust in PHCPs are: Vulnerability, Knowledge, Affirmation, Voice, Clinical Skills, Responsiveness, Professional Confidence, Thoroughness, Acceptance, Personal Connection, Honesty, Empathy, Reciprocity, Safety, and Empowerment. Collectively the men develop the following themes: Risk, Evidence, Autonomy, Personal Connection, Clinical Skills, Professionalism, Empathy, Friendliness, 'Reading' Skills, Honesty, Reciprocity, and Alliance. Finally, the discussion elaborates the participants' theorising by connecting it to existing marketing literature. The research finds that there are both profound relational and social dimensions to trust in this service context. Trust is understood as a relational phenomenon through the heuristic device of the 'She'/'He', 'Other', and 'They'.

This research extends the relationship marketing literature by developing a deep understanding of the phenomenon of trust from the patients' perspective, and the interconnections between this trust and gender as it is lived in health care service contexts. These insights provide a sound base for implementing improvements to current health care practice that are valued by the patient, and therefore have immediate practical relevance for health care practitioners, health care policy makers, and patients. This research also contributes academically by establishing a new way of analysing and interpreting relational phenomena such as trust.

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1: A Question of Trust

*“Never trust a doctor whose house plants are dead.”
(Magnet on Mary R’s fridge)*

1.1 Introduction

Trust is an important and essential part of our daily personal lives and as service transactions become more relational, it is assuming a critical role in our business transactions too. There is a great interest by marketing theorists in the topic of trust and a growing body of literature on the subject, particularly within the relationship marketing field. However, very little is known about how consumers experience the phenomenon in their consumer-provider relationships. The research available regarding trust in services concentrates almost entirely on trust from the provider’s perspective. Moreover, these studies neglect the social and cultural construction of the phenomenon they set out to ‘capture’. There has been a notable lack of attention given to how trust is lived and understood by the people experiencing it.

To study trust only from the service provider’s point of view cannot get at the nature of trust as it is experienced by the consumer. Indeed, the description of a trustful relationship made solely from the provider’s perspective might be quite incongruent with the consumer’s perspective of that same relationship. It is only when consumers articulate trust for providers that we can begin to make real progress to provide consumers with relationships that they can experience as trust-filled.

The purpose of this research is to make a meaningful contribution towards understanding the trust phenomenon and its interactions with the social processes of gender, from the perspective of one particular group of service consumers, patients of primary health care practitioners. Therefore, it focused entirely on trust as it was lived by patients – their experiences, their feelings, their meanings, their beliefs about trust in the context of primary health care. Because of this emphasis on the women's and men's lived experience of trust, the research used an interpretive research method.

1.2 So What's the Problem?

The problem of this research was stated: From the perspective of the patient, what is the experience of 'trust' for male patients and for female patients?

Therefore, the overall aim of this research was to explore the phenomenon of trust by obtaining from the written descriptions and verbal discussions of male and female patients their perceptions of trust experiences with primary health care practitioners. More specifically, I sought to describe and explain the trust that these patients experienced, and to explore the meanings that the males and females themselves ascribed to trust in a health care service context.

Theoretical and Practical Significance

Although the research problem involved the interrelationship between the personal and social for the patient, this study focused on how the individual's experience of trust in primary health care practitioners was socially located (rather than

individualistically). Specifically, the research explored the participants' understanding of how their individual experiences of trust had been shaped by the social processes of gender. To date, there has been little academic research into the implications of consumer gender differences in the field of relationship marketing in general, or in the health care industry in particular. This research problem, therefore, has immediate theoretical relevance for marketing academics and researchers, and is geared to fill a void in the existing literature on trust.

At the level of primary health care practice, the research topic stands to offer practitioners insights into how patients experience trust in them, and thereby provide a basis for developing more effective relationships that will raise the quality of the service encounter itself, and ultimately improve the well-being of patients. Thus, the topic has immediate practical relevance for health care practitioners, health care policy makers, and patients.

Personal Significance

The research has important personal significance. Issues of trust and gender and health care are prominent in my personal life. The research topic was incubating for the 14 years that I was actively involved in a primary health care practice. This was a privileged position - I heard both the stories of patients and the stories of the practitioners. Patients' stories revealed how critical trust was in the 'success' of their health care and general well-being. Practitioners' stories revealed how hard it can be to make personal connections with patients that are deep and meaningful, and able to be sustained within relationships that are healthy for both. So, I have been privileged to watch trust being established and nurtured as something precious within patient-

practitioner relationships. I have also watched it being faked, dismissed, ridiculed, and dishonoured.

Turning to gender, the health care system seems to be failing men and women differently. New Zealand men are more reluctant than women to use it, and women are being increasingly let down by health care providers and processes (Dew & Kirkman, 2002; Harwood & Sparks, 2003). Over the years I was actively involved in the health care industry, I came to suspect that male and female patients live ‘trust’ in their health care provider differently, and that these differences often are not recognised, understood, or respected by primary health care practitioners. This research is partly driven by my personal curiosity about the interconnections between trust and gender, and their implications for health care services.

The Terms ‘Trust’ and ‘Gender’

It is not appropriate that I provide a definition of ‘trust’ – this would negate the purpose of the entire project (to explore what trust means for patients). Thus, I do not define ‘trust’ for the reader at this stage. Nor did I provide an operational definition of ‘trust’ for volunteers, but had them commit themselves to the project on their own judgement that they had experienced trust and were therefore qualified to participate. I am confident that by the end of this document I will have represented full descriptions of what ‘trust’ meant for these participants as patients. In this way, I am endeavoring to bring ‘trust’ back from the metaphysical way it is used and argued by theorists, to its everyday use by the people who live it in their relationships with health care providers (Wittgenstein, 1953).

Throughout the research I use the term ‘gender’ to refer to the social meaning of being a man or a woman. The term therefore refers to gender as a social construction, implying the diverse ways in which men and women are socialised and educated throughout their life experiences into different ways of living masculinity and femininity. This is in line with how the term ‘gender’ is commonly used in the literature (e.g., Germov, 1998; Lane & Cibula, 2000; Lupton, 1994). The concept of gender is discussed more fully in Chapter 3. I also use the words ‘male(s)’ and ‘female(s)’ in their fullest social sense, rather than as categories that merely denote biological sex.

1.3 Research Questions

Main Research Question

The central question of this research was: “How do male and female patients describe and perceive the experience (positive or negative) of trust in primary health care practitioners?”

The major components of this question are denoted by the words ‘how’, ‘describe’, ‘perceive’, and ‘experience’. The word ‘how’ enabled me to frame the question clearly and indicated my openness to whatever emerged about trust in the course of the research. ‘How’ reflected the overarching aim of this research to explore the meanings, variations, and perceptual experiences of trust for these male and female patients. My intention was to represent ‘how’ patients lived trust, and ‘how’ they understood gender related to their trust experiences.

‘Describe’ referred to the meanings of trust that were revealed by participants. I was aiming for descriptions rich in both detail and emotion, that evoked what Denzin refers to as “emotionality and self-feelings” (1989, p. 83); such rich description would establish a sound foundation for interpretation that would clarify and deepen our understanding of trust.

The word ‘perceive’ acknowledged the relative nature of trust; that trust is perceived differently by different people, and by the same person in different situations.

‘Experience’ pointed to the fact that I was seeking careful and comprehensive stories from individual participants that expressed the nuances of the trust phenomenon as they each lived it. I invited participants to explore both positive and negative experiences of trust to allow for the possibility that we might learn more about the nature of trust by exploring those situations when trust is compromised or lacking in some way.

Research Sub-Questions

The following sub-questions, designed to narrow the focus to particular aspects of the inquiry, were nonetheless fairly general to avoid constraining the inquiry in any way. They were intended to function as a guiding framework, flexible enough to allow for refining and reformulation throughout the research, in keeping with the principles of emergent design. At all times, I endeavored to honour the essential perspectives brought to the fore by the participants.

- How did these male and female patients describe their trust in a primary health care practitioner? What did they perceive 'trust' to mean, in this context? How did they conceptualise trust?
- What was the nature of trust that these male and female patients experienced in their primary health care practitioners, according to the participants? What were the facets of the phenomenon? (Cognitive? Emotional? Physiological? Behavioural?)
- What facets of the trust experience were most important and/or dominant in the primary health care context?
- What variations were there in the experiences? What similarities were there? What trust patterns existed among and between these men, and among and between these women?
- What aspects of their lived trust did participants identify as being gendered?
- How did participants understand these gendered aspects? How had it come about that similarities/differences occurred in the trust experiences of these men and women?

These subquestions all served the objective of understanding and interpreting the meaning of patient trust, how it was experienced, and how it was interwoven with the social processes of gender. The research questions were intended to be a guide only, allowing for both the questions and the perspectives behind them to be refined throughout the research.

1.4 Research Approach

The research aimed to discover the patients' own perspective on trust and gender, rather than to presume that I (as designated researcher for this academic exercise) already knew what the appropriate 'questions' and 'answers' were. This, in addition to the fact that the research involved exploring the relatively unknown topic of patients' trust experiences, meant that qualitative methods were the appropriate choice for gathering the data.

The qualitative method of Memory Work was chosen as a particularly effective qualitative method for gathering the data for this research. An interpretive, field-based method, Memory Work allowed the patients to describe their experiences to the other participants, and make comparisons between their experiences in order to develop a sense of how much similarity and diversity existed among participants. This work enabled us to analyse and interpret for regularities and common themes. Furthermore, in the group theorising, the method uncovered the ways in which these men and women themselves made sense of gender and their trust experiences in the health care context.

The research involved two groups of participants, one group of five female patients, and one group of four male patients, as the 'experts' on the topic. Following the Memory Work method the participants independently wrote detailed narratives of their lived experiences of trust, evoked by agreed 'trigger' topics that each group felt explored and represented trust within the patient-practitioner relationship. The participants then came together as a group to discuss and analyse the individual narratives for the 'common' sense or the social aspects of the experiences common to

the group, and the processes used to make sense of them. Both the women's research group and the men's research group met for five sessions, each session lasting at least three hours. Between them the research participants wrote 43 individual narratives (two absences due to illness) and generated more than 30 hours of recorded group work. After the participants' collective work to locate within their personal experiences the key statements that spoke directly to the phenomenon of trust and its distinguishing features, I worked alone to relate these experiences and findings to existing theories.

The research resulted in phenomenological-type descriptions of the experience of trust, and interpreted the gendered themes and patterns in trust as these patients lived it. It also explored how these participants understood their trust in their health care practitioners had been gendered. My hope was that in providing 'thick' description and 'thick' interpretation of patient trust we would construct a sound base for a deep, authentic understanding of the phenomenon in this context (as explicated by Denzin, 1989).

1.5 Research Parameters

Overall, the final parameters of the study set as the *process* of interest, the relationship between primary health care practitioners (the service providers) and male and female patients (the service consumers); as the *events*, the 'trust experiences' (positive and/or negative) of those men and women within their patient-practitioner relationships; as the *actors*, the men and women participating in patient-practitioner relationships as

part of their health care consumption; and as the *setting*, any primary health care service.

The ‘relationship’, per se, was not defined for the participants. Again, I deliberately left the definition to each individual participant. This follows Czepiel’s contention (1990) that a relationship exists when exchange partners recognise a special status, built on particular relational bonds, between them; it also responds to calls for customers to define the concept from their own points of view (Liljander & Strandvik, 1995; Rao & Perry, 2002; Wong & Sohal, 2002). Thus, participants were able to present as ‘relationships’ both single interactions (traditionally labeled ‘discrete transactions’ in the marketing literature, e.g., Dwyer, Schurr, & Oh, 1987; MacNeil, 1980) and multiple interactions with the same practitioner over an extended length of time.

‘Primary health care practitioners’ are those health care providers who people in New Zealand can themselves choose to use without first needing to obtain a formal referral from another health care practitioner. Such primary health care practitioners include, for example, general practitioners, dentists, physiotherapists, chiropractors, osteopaths, alternative healers, and midwives. ‘Patients’ are recipients of health care, that is, people who have made contact with the health care system to consult with health care practitioners (after Baumann, Deber, Silverman, & Mallette, 1998). This framework for setting the boundaries of the data collection activities follows that suggested by Miles and Huberman (1994).

1.6 Thesis Structure

To achieve the aim of this research and answer the questions framing the study, the chapters of this thesis are structured as follows: Chapter 2 considers the contexts of health care within which the participants live and construct their trust as patients; In Chapter 3 discussion focuses on the theoretical understandings of trust and of gender, and their interconnection. Chapter 4 addresses the methodological issues relevant to this research design, while Chapter 5 outlines the qualitative method Memory Work, and details how it has been applied in this research. Chapters 6 and 7 describe and explain the phenomenon of trust lived by the women and by the men respectively, presenting their work in the themes they constructed to make sense of their trust experiences. Chapter 8 links the participants' work to theory, exploring the similarities and differences between the trust themes used by the women and the men, and developing theoretical links between gender and those experiential themes. Finally, Chapter 9 brings together the conclusions of the research, and discusses their implications for theory and practice.

Points of Presentation

- Throughout the document Primary Health Care Practitioner(s) is abbreviated to PHCP(s) after the first mention in each chapter, when it is in full. Similarly, after the first mention, General Practitioner is abbreviated to GP.
- Inverted commas and capital letters are used to demarcate words or terms with a specialised meaning. They are signals to the reader that certain words require a specific interpretation and therefore need to be considered carefully. For example,

I spell Soul with a capital letter to signify that it refers to the deeper aspects of the mind and self of a living person (as opposed to a departed spirit).

1.7 Locating the Researcher: Where ‘I’ Come Into It

This thesis document is a bi-lingual one; written both in the language of academics, and in the personal language that is located in me, Mary FitzPatrick, the gendered, historically situated, interacting individual human being. I write myself, my reflections, and my understandings into the text at those times when it is important and appropriate that I make a personal, subjective statement on the research process. I include these statements freely in the belief that they will help to explain my place in the PhD experience as a connection between you the reader and the men and women who volunteered their stories for this thesis. With this knowledge you will be better able to assess the impact of my subjective experiences and presence on their work. I add my voice in the hope that it will contribute to a constructive dialogue between us, which results in a deep understanding of patients’ experiences of trust.

I weave my story into the academic text too as a way of charting the journey this has been for me as an individual and as a researcher – these personal threads chart my progress, celebrating glimpses of the Big Picture, and marking the speedbumps I hit along the way. Academic tradition has worked diligently to de-face the researcher and deny the emotion-charged dynamics of the research journey. Academic language is not equipped to tell those stories. While the bi-lingual approach might suggest some degree of schizophrenia, I assure you that I have lived the PhD as a startling but very rich whole experience. My story is simply another layer to the narratives on which

this research is constructed. My personal statements will appear throughout the document in italics and under the heading “In My Own Words”.

1.8 In My Own Words

I am a European woman, of Irish descent, a Catholic, with an abiding interest in the spirituality of human beings. My Mum was a bookkeeper and Dad was a social worker: we moved regularly as Dad followed the standard Government promotion path to the top of his ladder. Now I am approaching that stage of my life that is generously referred to as the Golden Years, a time popularly believed to be characterised by deep wisdom. I look forward to it. My five beloved children, the path-markers around whom my career(s) path has careened off periodically into teaching, journalism, and health care, have accompanied me. Any gaps in the traffic that were big enough I have filled with study and gardening.

This research and the thesis have been written over a period of time in my life that has been shaped importantly by the experience of divorce after a 28-year relationship. I have emerged from this with a lot of black socks, a garage full of power tools, and a keen awareness and sensitivity to issues of respect and trust within our relationships. On a very deep personal level then, I believe passionately that each of us has the right to live and speak our construction of truth without fear of censure, rejection, or reprisal.

Trust is the bridge we use to step out from our own positions of vulnerability to meet another. The quality of our relationships depends on trust that the other will respond

to us with acceptance, compassion, and lack of judgement. I believe that these dynamics are critical to the success of our relationships with family and friends, and also to those 'intimate' relationships we have in the marketplace, usually with the providers of services perceived to be high risk, such as professional services like health care, legal services, and accountancy. The whole complex phenomenon of trust, what it means to individual men and women, how we live it in different contexts, and its place in our relationships holds a deep fascination for me. Now, I am at a time when I can step back and declare that yes, my research interests have been well fuelled by the major events in my own family circumstances.

2: Putting Health Care into Context

“Meaning is always within context and contexts incorporate meaning.” (Mishler, 1979, p. 14)

2.1 Introduction

The context of health care is very complex. It is composed of separate smaller contexts with distinct features that nevertheless are interdependent because of the components that they share (Sheehan & Brenton, 2002). For us to fully understand trust as it is experienced by the participants it is critical that we consider the contexts within which their meanings of trust have been constructed.

The contexts range from the wider social context in which ‘health care’ is a shared perspective on illness and well-being, shaped by cultural, political, economic, and ideological forces and constraints; through to the relational context of a single experience of trust between a patient and primary health care practitioner (PHCP), which accounts for the immediately relevant aspects of the situation for the individual. Every relationship between a patient and a practitioner is developed within these health care contexts. Therefore, certain characteristics of the relationship, its depth, and its importance will be shaped by contextual factors. My aim, by exploring the matrix of contexts implicated in trust, is to illuminate the connections between the personal trust experiences of the participants and the social constructions of the phenomenon.

The chapter is organised into two broad parts. The first part focuses on understanding three distinct contexts of health care. It begins by mapping the global context of health care, then presents an overview of the New Zealand health care context, and finally, discusses the patient-practitioner relationship as the specific immediate context for these experiences of trust in primary health care practitioners. In the second part of the chapter I review, from a marketing perspective, the implications of health care services in general, and of the patient-practitioner relationship in particular.

2.2 The Global Context of Health Care

Globally, health care today is characterised by change, complexity, and escalating costs (Albrecht, Fitzpatrick, & Scrimshaw, 2000). There have been pervasive and profound changes worldwide in the discourses, organisation, and provision of health care over the past five decades. These changes in the global health care context, which have produced both spectacular innovation and intense unrest, have been fostered by:

- criticism of the biomedical model of health (see Armstrong, 2000),
- the development of new technologies, particularly information technology and biomedical technology (Samson, 1999),
- the involvement of the state in the delivery of medical health care and growing intervention by third parties (Frenk & Duran-Arenas, 1993), and
- the global transfer and adoption of industrial capitalism, which have in turn given rise to materialism, individualism, and consumerism (Samson, 1999).

Medicine and the Biomedical Model of Health

Historically, the medical profession is regarded as the dominant force that has shaped, and continues to shape modern Western health care systems, practices, and experiences of illness/health. It is based on a model of health known as the biomedical model, which in turn has nurtured a health care culture founded on a patriarchal positivism that emphasises control through rationality and separation (Miller & Crabtree, 2000). Everyday characteristics of the biomedical culture include male-centredness, physician-centredness, the importance placed on credentials, a process orientation to health care, focus on short-term results, a ‘reverence’ for the privacy of the doctor-patient relationship, and intolerance of other health care modalities (Miller & Crabtree, 2000).

The specific features of the biomedical model that are most relevant for this research are:

- The body is a separate entity from the mind. The body is constituted as an external physical object able to be freely inspected (Samson, 1999). This view reaches its fullest expression in biomedicine as the Cartesian dualism of mind and body.
- The body is a machine. The body is seen as a complex machine, made up of separate anatomical parts and physiological systems, that doctors are able to repair using specialised technical knowledge (McLennan, Ryan, & Spoonley, 2000).

According to this mechanical metaphor, the objective, clinical signs of illness are observable by the doctor and independent of the symptomatic experience of the patient (Gordon, 1988, as cited in Annandale, 1998, p. 6). Technological

interventions are regarded as important factors in health care: a technological imperative operates because the body is treated as a machine.

- The development of an aetiological framework (notably the germ theory) to understand and treat disease (Armstrong, 2000; Bates, 2000). Although this framework made possible many of the biomedical advances of the last century, its focus on the physical expression of the patient's illness effectively separates the body from its sociocultural environment and ignores the psychological factors involved in health (biological reductionism). Indeed, some theorists (e.g., Lupton, 2000) hold that it was biomedicine's doctrine of aetiology specifically that made molecularised medical science "the instrument of the physician's power" (Cassell, 1989, p.13) and thus enhanced the privilege of medical practitioners.

The Biopsychosocial Model of Health

In the second half of the twentieth century, theorists from various disciplines began to express their concerns at the dominance of biomedicine in health and health care, as well as the extent of its social and cultural authority. Notable among the psychological and social models of health that emerged at that time was the biopsychosocial model of health. Established during the 1970s (mainly by Engel), this model combined elements of the biomedical model with the newer research of social scientists, to identify the psychological and sociological factors in health and illness. This and other social models of health from that time underpin much of our contemporary theorising on the social construction of health experiences (Armstrong, 2000).

More recently, Foucault's work and the traditions of postmodernism and feminism have stimulated important critical responses, both to the biomedical model and to the more recent social models (Annandale, 1998; Armstrong, 2000; Frankel & Beckman, 1989). Finally, the development of the sociology of emotions (James & Gabe, 1996; Williams, 1998; Williams & Bendelow, 1996) provides us with a theoretical base for re-connecting emotions and the body, which takes more sophisticated account of the relationship between social relations, psychological processes, and biological processes.

Changing Patients

At the same time as the theoretical landscape of health care has been changing throughout the Western world, patients have become increasingly 'conscious' in regard to their health care experiences. Generally, they have become much more informed as information technology has given them access (directly via the World Wide Web and indirectly via other mass media) to expert knowledge that was previously held by medical practitioners. As this specialised knowledge base has become more accessible to the public, the status of the medical profession has been eroded, and the power and control mechanisms that rested on the disseminating of that exclusive knowledge have diminished (Coburn & Willis, 2000; Coulter & Fitzpatrick, 2000).

Information technology, combined with twin emphases on individual responsibilities and choices within a consumer society, have been major factors in empowering people to take a more active role in their own health care (Lupton, 1994). At the broad

social level, such empowerment is evidenced in the growing trend to self-help health care (e.g., self-diagnostic kits and off-the-shelf treatments), and the use of health support groups (e.g., cancer support groups) or more informal social networks for health-related advice (Hardey, 1998). Organised groups, such as those that sprang up around AIDS, also can influence public perceptions of particular health issues and thus be powerful vehicles for health reform.

Complementary Health Care

Accompanying the growth of consumer dissatisfaction and unease with biomedicine has been public interest in non-medical health care philosophies and practices (Hardey, 1998). Commonly referred to as ‘alternative’ or ‘complementary’ health care practices (comparative labels awarded relative to biomedicine), these health care practices are now relatively common and generally accepted in the wider health care context. Most of these practices offer a more humanistic, patient-centred approach than scientific medicine (Bates, 2000), acknowledging the importance both of mind and soul in the individual’s experiences of health and of the sociocultural context in which health is situated. (See Cant and Sharma, 2000, for an excellent discussion of the worldwide rise of non-medical health practices.) Many of today’s health care consumers use both ‘complementary’ and biomedical therapies, and they perceive no conflict in using both (Coile, 2002).

Political Changes

As a result of the serious challenges during the 1970s to the autonomy and credibility of the medical profession, governments around the world became heavily involved in the business of health care (Coburn & Willis, 2000; Hardey, 1998). A decade later, competitive health care and then privatisation became global trends as economists, politicians, and business leaders adopted various market approaches to health care (Hardy, 1998). These approaches have contributed to the shift from the professional dominance that prevailed under biomedicine, to buyer dominance, with payer-led emphases on better outcomes, prevention, and primary care (Light, 2000). While the benefits of such changes and their concomitant reforms must be acknowledged there is criticism that many health care providers are losing touch with the perspectives and needs of their patients (Williams, 1993), and that the reform initiatives have failed to achieve their objectives (Richards, 1996). The World Health Organisation formalised the concern of members over market-driven cost containment in its call for a return by health care policy makers to a focus on human dignity, equity, solidarity and professional ethics (1996).

Health Care Inequalities

Wide inequalities in levels of health and access to services continue to persist among and within countries (Flaskerud & Nyamathi, 2000), and there are also widespread reports of unease among health care practitioners that the quality of the health they

can deliver is being compromised by the constraints imposed by the restructuring of health services into profit-driven businesses (Beecham, 1996; Issel & Kahn, 1998).

Socioeconomic inequalities in health stand as one of the major problems of Western health care today (Curtis, 2004). A number of recent sociological analyses suggest that these health inequalities, manifest across individuals, communities, and societies, are on the increase (see Robert & House, 2000). Not surprisingly then, there has been a global movement to focus on the determinants of health inequalities. Health research and policy commonly identify social class, ethnicity, and gender as major factors in health. For instance, it is now recognised that the marked difference between the mortality and morbidity rates of women and men can be best understood by reference to the social construction of gender and the gendered social practices that contextualise individual health care experiences (Henshaw & Howells, 1999; Lane & Cibula, 2000).

In market models of health care provision the individual patients are the end-consumers of health care products and services. The commercial importance of their needs and wants, and their levels of satisfaction grant them a key position in the health care marketplace. This position has been reinforced by the rise of the consumer culture and dominant ideologies such as individualism – both of which have been major forces in reshaping the expectations and roles of the contemporary health care consumer (Samson, 1999) in the reconfiguration of the global health care context.

The contemporary Western health care consumer is now faced with considerable choice and increased responsibility in consumption of health care services and

products. With globalisation, health care knowledge is becoming more complex and contested (Annandale, 1998), and thus the choices we make as patients carry more potential risk and uncertainty.

Moreover, we make our choices in a dynamic, complicated health care context that has developed quite forceful moral imperatives concerning self-responsibility for health (Fox, 2000; Lock, 2000) and a profusion of competing interests (Flaskerud & Nyamathi, 2000). As patients in today's health care context, we find ourselves compelled to seek information and make choices. Yet, as Annandale (1998) astutely remarks, "the ability of the patient to do this is very much circumscribed by the highly politicized nature of the health-care milieu" (1998, p. 280).

To summarise, health care in the global context is expansive and expensive, complex and subject to rapid change. These features are consistent with the claim that "capitalist society itself is becoming more fragmented and less fixed, involving a shift to a 'postmodern society' characterized by fragmentation, fluidity and uncertainty" (Carpenter, 2000, p. 37).

Today, patients have a wide range of health care options, and therefore much more choice in their own health care. While medicine remains a powerful presence in the global context of health care, complementary health care therapies and more holistic, patient-centred approaches to health are gaining wide acceptance, as we become increasingly aware of the shortcomings of biomedicine. However, the pluralism and complexity that characterise the health care sector today not only present patients with

opportunities but also new challenges that are linked to notions of uncertainty and risk.

We would seem to be in a transition period, when 'health care' as a construct is being reconfigured globally. Changes that occur at this global level of the health care context impact the values, roles, and expectations that practitioners and patients alike have for the design and delivery of health care services within Western society. As worldwide recognition grows of the hegemony of biomedicine and the taken-for-granted medical discourse of health and illness, individual patients are finding that they must negotiate and re-construct new ways of understanding their health care experiences in the interim.

2.3 The New Zealand Health Care Context

Broadly speaking, health care in New Zealand reflects the global patterns and changes discussed in the previous section. This is to be expected, given that there are marked similarities across industrial societies in the construction of health care practices and beliefs, as well as the organisation of the health care system itself (Davis, 1981).

However, because of the sociocultural and historical differences between New Zealand and other advanced industrial societies, it is important that we understand the nation's health care context in its own right. The following section will review the New Zealand health care context, with the focus on primary health care, up until the end of 2001 when the participants for this research did their data collection.

Health Care Funding in New Zealand

Health care in New Zealand is funded and provided by various state, private, and voluntary sectors. Approximately 77% of health care is state funded. Public health expenditure amounted to \$6,490 billion in 1999, or \$1,705 per person (Statistics New Zealand, 2002). Primary medical-care services are provided by general practitioners (GPs), most of whom now work as members of group practices (as opposed to sole practice). The government subsidises the cost of GP visits for New Zealanders with low income or high health needs (although the GP can charge a co-payment), and for children (in certain circumstances). However, as the female participants in this research commented, it is becoming more common for low-income people to use their local hospital's accident and emergency department for primary health care needs because services are free for the patient i.e., fully subsidised by the government.

Various government subsidies also apply to prescription drugs and certain other pharmacy costs, dental services, maternity care, home nursing and home help. Finally, in "an arrangement peculiar to New Zealand" (Dew & Kirkman, 2002, p. 84), the state compensates accident victims for loss of employment and treatment expenses. Under this scheme, known as ACC (Accident Compensation Corporation), accident victims can receive subsidised treatment from a range of primary health care practitioners, including GPs, physiotherapists, chiropractors, osteopaths, acupuncturists, and others. Treatment from registered ACC practitioners can be free or heavily subsidised.

Reforms and Changes in the System

New Zealand's health care system has undergone significant and rapid change since the 1980s. These reforms, which have left many practitioners and patients "both weary and wary of change" (Somjen, 2000, p. 68) in the health care system, have come to be formally acknowledged as "the most radical of any OECD country" (Malcolm, 2000, p. 183). The reforms and subsequent restructurings reflect the changes in New Zealand governments over that time and hence the changes in political objectives for the health care system.

Consumerism has flourished over the course of these political and economic reforms to New Zealand's health sector (see Lysonski, Durvasula, & Watson, 2003), and New Zealanders increasingly challenge medicine and its dominance of the health care sector (Dew & Kirkman, 2002). Historically, successive New Zealand governments have conferred great authority on the medical profession by enabling it to operate as an autonomous profession with powers to regulate itself and determine the practice conditions of its members. (Fougere, 1984, as cited in Davis & Dew, 1999, p. 9). In the last few decades however, New Zealanders' trust in medical practitioners has weakened significantly. This is due partly to global trends such as increasing skepticism and scrutiny of social institutions like medicine, and people being able to access detailed health information themselves without having to rely for it on their medical practitioners (as discussed in the previous section of this chapter, 2.3 The Global Context of Health Care).

Equally important though in fuelling this consumerism within the New Zealand health care context has been the impact of a number of medical mishaps that have been detailed in the media and extensively followed by the public. The run of these mishaps is popularly regarded as having started with the ‘Unfortunate Experiment’ at National Women’s Hospital in Auckland. In 1987, a national monthly magazine published an article reporting that women suffering with cervical cancer had been unknowing subjects in an experiment at National Women’s in which treatment for their cancer was with-held (Coney & Bunkle, 1987). By the 1980s at least five women had died as a result of the experiment and 40 had developed invasive cancer (Snook, 1999, as cited in Dew & Kirkman, 2002, p.154).

The discovery of this experiment and the subsequent inquiry basically revealed that the values held by the medical profession were not the same as those held by the New Zealand public, and that the medical profession was too quick to excuse and protect members who made ‘mistakes’. After the inquiry had exposed the established peer review processes as untrustworthy, the office of Health and Disability Commissioner was created to investigate complaints made against all health care practitioners. Since then, medical scandals involving both health care institutions and individual practitioners have further undermined the view of medicine as “a purely benevolent act practised by altruistic individuals who base their judgements on a bedrock of certain science” (Dew & Kirkman, 2002, p. 148).

Another particularly important factor in the rise of consumerism in New Zealand has been the development of powerful pressure groups that lobby on behalf of health care consumers. These include lobby groups, usually well-organised and articulate, with a

high public profile, that focus on specific health concerns (e.g., mental health or immunisation) and groups that have developed out of the women's health movement (e.g., homebirth groups or women's health collectives).

Gender and Health Care in New Zealand

Health inequalities based on gender differences in the experience of health are identified as an area of special concern in the government's health reform strategies. The gender inequalities manifest in the New Zealand health care context are very similar to the patterns identified in other industrialised Western countries around the globe. Thus, in New Zealand:

- Women have a longer life expectancy than men. Men's life expectancy is 76 years, almost five years less than women's (Goodyear-Smith & Birks, 2003).
- Women's life expectancy has decreased as men's life expectancy has increased. Life expectancy decreases as deprivation increases (Ministry of Women's Affairs, 2002).
- 'Men die quicker but women get sicker.' Women suffer from more illness and disability than men, even when they are the same age (Davis, Graham & Pearce, 1999).
- Men use primary health care services less than women and are more likely to put off seeing a primary health care practitioner when they are ill (Dew & Kirkman, 2002). Women obtain more prescription items than men (Goodyear-Smith & Birks, 2003).
- Men are more likely than women to die from suicide, homicide, and unintentional injury (Feyer & Langley, 2000).

- Total New Zealand registrations for cancer specific to women number 764 per 100,000. Male-specific cancers total 1226 per 100,000 (Ministry of Health, 1999).
- Women and men have similar overall rates for diagnosable psychiatric disorders, although women have higher rates of depression and anxiety (Ministry of Women's Affairs, 2002).

While these figures do reflect gender differences in the actual contact with the health care sector, they do not detail the relationship between gender and health experiences in New Zealand. Sociologists remind us that such statistical information on gender inequalities must be understood in relation to the different roles that women and men are socialised into, along with the political, economic, and historical forces that contribute to gendered experiences within the New Zealand health care context (e.g., Dew & Kirkman, 2002; McLennan, Ryan, & Spoonley, 2000).

Thus, gender makes most sense as a determinant of health when it is connected with other major practices and patterns within New Zealand society. For instance, sociologists suggest that the New Zealand culture of masculinity fosters risk-taking, problems with alcohol, difficulty expressing emotions, and reluctance to seek help (see National Health Committee, 1998). For women, the role of single parent is increasing. In New Zealand, women who are separated from the father of their child are more likely than other mothers to be depressed and economically disadvantaged into middle age (Coney, 2002; Williams et al., 1997).

There are socially prescribed behaviours for men and women as part of their work roles, relationship and parent roles, and patient roles (particularly within the

traditional biomedical model for patient-practitioner interactions). So, the statistics that show New Zealand men have higher rates of workplace deaths than women, for instance, can be partly explained by understanding that occupations such as forestry, fishing, and agriculture are regarded traditionally as ‘male’ occupations (Dew & Kirkman).

Other gender inequalities in health can be understood when we situate them in the wider economic context:

The individualism unleashed by the economic restructuring of the 1980s and 1990s led to both an increase in inequalities and an increase in anomie as people were encouraged to look after themselves and not others. Indicators of the impact of anomie could be seen in the increased suicide rates during the 1980s, particularly affecting young men, the unemployed, and sickness beneficiaries. (Dew & Kirkman, 2002, p. 37)

Women in New Zealand do not yet have full equality with men in economic and social status, freedom from discrimination, and access to decision-making processes and opportunities, despite the fact that women and men do have equal status under law (Statistics New Zealand, 2002). The Ministry of Women’s Affairs, which advises the Government on issues that disadvantage women, has developed a women’s health strategy on the basis that women have special health needs not met by the previous health care systems. The Ministry states that it uses a gendered approach to health policy, rather than a women’s health approach, to enable a focus on men as well as women, and to work with New Zealanders from different ethnic and cultural backgrounds (Ministry of Women’s Affairs, 2002).

However, policy commentators Goodyear-Smith and Birks (2003) warn that initiatives that give priority to women’s health care services (e.g., the 2001 Women’s

Health Strategy) have disadvantaged men in New Zealand, by neglecting men's health issues and ignoring the barriers which make it difficult for men to access health care services. They draw attention to several reports produced by New Zealand government organisations that are critical of men and sympathetic to women. Such responses to gendered health inequalities, they claim, reflect a trend in health care suggesting that men themselves are to blame for their health problems because of certain masculinist traits they exhibit.

Goodyear-Smith and Birks urge policy makers to “show men that they are not being blamed, but rather that they are valued enough to be allowed to care about their own health” (2003, p. 28). They advocate health care strategies that acknowledge the value of both men and women in New Zealand society, with specific policies targeting those in need because of a particular health problem. For example, policies designed to address problems such as suicide and workplace injury would largely target men. Such approaches to health inequalities are needs-driven: they recognise and respond to patient needs rather than gender stereotypes. They represent movement in health care policy away from practices based on the dualistic conceptualisation of gender to post-modern understandings of gender as a dynamic phenomenon interacting with other key social forces that combine to create the context for any health care incident.

The preceding section has outlined the New Zealand context for health care, especially as it relates to primary health care. It is a context that has experienced substantial changes over recent years. Some of these changes reflect patterns evident in the global health care context, such as the disillusionment with biomedicine, the

rise of consumerism, and increasing levels of health knowledge. Others of these changes and certain structures in the national context are the result of distinct social arrangements that are unique to New Zealand, for instance, the level of state funding for health care, and special initiatives to address Maori health issues. Commentators agree that the roller-coaster changes to New Zealand's health care sector have not been successful in the long term, in cost savings, health outcomes, or equity (e.g., Barnett & Barnett, 1999; Gauld, 2001; Somjen, 2000).

The health care problems the country faces are the drivers of these changes – costs, demand, expectations, and politics. Patients have driven some of the changes directly, through consumer lobby. However, consumer pressure groups and complementary practitioners are situated in a national context in which medicine continues to be the privileged discourse on health and the delivery of health care to New Zealanders. groups, and indirectly by changing their health care consumption patterns and preferences. However, consumer pressure groups and complementary practitioners are situated in a national context in which medicine continues to be the privileged discourse on health and the delivery of health care to New Zealanders (McLellan, Ryan, & Spoonley, 2000). Issues affecting women's health, in particular, have been prominent in this context because of the media coverage of a series of medical scandals around cervical cancer, and other medical 'mishaps' involving women patients.

These then are some of the distinguishing features of the New Zealand health care context. It is from within this national context that individual patients shape their personal health experiences and their relationship to health services and practitioners.

The next section discusses the patient-practitioner dyad as the ‘micro-context’ of health care.

2.4 The Micro-Context: The Patient-Practitioner Relationship

Health and illness are fundamentally personal and private experiences: the pain and discomfort of illness occur within each of us individually. But our experiences of health and illness are also extremely social. The ways in which each of us interpret and respond to our individual symptoms are shaped by our social context, including such determinants as ethnicity, social class, and gender (Mayer, Davis, & Schoorman, 1995). The patient-practitioner interaction is an important aspect of a person’s health/illness experience. It is in the context of this relationship, for instance, that our physiological symptoms are transformed into diagnoses, and we learn and practise socially appropriate illness behaviour.

The patient-practitioner relationship exists between a person who feels or is told that s/he is sick or ill in some way, and a person who provides therapeutic help. The category of ‘patient’ comes into being when that person, who is experiencing a health care problem, consults a practitioner who can provide “preventative, curative, comforting, caring and diagnostic interventions” (Ramdass, Naraynsingh, Maharaj, Badloo, Teelucksingh, & Perry, 2001). Merely having symptoms of ill-health is not enough to make a woman or a man a patient – actively seeking help from a health care practitioner does.

The interaction between patient and practitioner constitutes a formal relationship, in the sense that they meet for a limited time, for a specific purpose based on the assumed common goal of patient well-being and health, and the practitioner receives a fee for her/his services (von Friederichs-Fitzwater & Gilgun, 2001; Nadelson & Notman, 2002; Walker, Arnold, Miller-Day, & Webb, 2001). Accordingly, this research accepts that the term ‘relationship’ can encompass both a one-off encounter when, for the duration of that single consultation, a patient relates to a PHCP whom s/he might never interact with again (e.g., in the case of an emergency), as well as a series of encounters between a patient and the same PHCP over time. Because such interaction between two people is a fundamental notion in both services marketing and relationship marketing, the particular context of the patient-practitioner relationship assumes great importance in this research.

Relationship Complexities

The patient-practitioner relationship can be very complex, due largely to the circumstances in which it is created (Budd & Sharma, 1994). The patient enters the relationship because s/he believes that the practitioner has expert knowledge, skills or techniques that can help achieve specific health needs. The practitioner believes that s/he can help the patient to meet health care needs because s/he possesses expert knowledge, skills, or techniques that will contribute to the patient’s well-being (Agich, 1983). Patient reactions to these circumstances can range from vulnerability and dependence to consumerism and self-responsibility. In these circumstances, issues

of power and dependency can become serious relational problems (Doney & Cannon, 1997; Kumar, Scheer, & Steenkamp, 1995).

To add another dimension of complexity to the patient-practitioner relationship, the participants can bring entirely different perspectives into the consultation room (Davis, 1981; Roter & Hall, 1997). The patient is, of course, personally involved with the health issue, living it as an experience that is affecting the quality of their day-to-day life, and possibly fearing that it could affect their future well-being (McAlexander, Kaldenberg, & Koenig, 1994). Illness is a state of being that is often accompanied by feelings of uncertainty, vulnerability, risk, and fear. In contrast, the practitioner approaches the encounter with a certain detachment, seeing the patient's situation in terms of broader principles of health care. Because illness is socially constructed, patients and practitioners are likely to see the same set of physiological symptoms entirely differently (Lorber, 1997).

More of the complexity inherent in the patient-practitioner relationship is accounted for by those theorists who explore the parallels between it and other intimate interpersonal relationships, particularly in regard to tensions between self-disclosure and privacy, and the strategies used to negotiate conflict resolution (e.g., Berger, 1999; Grossman, 1998; Rimal, 2001). The reactions and experiences of the patient within the relationship further depend on diverse factors including the nature of the health care condition itself (e.g., physical or mental, acute or chronic), how the patient constructs her or his own role, and the personal and/or professional paradigms from which the practitioner responds (Dew, 2001).

Gender Effects in the Patient-Practitioner Relationship

Gender effects also have an influence within the micro-context of the patient-practitioner relationship. The relationship constitutes a social context, in that it is the purposeful meeting of two individuals within the health care system as it is organised and supported by society. Social contexts are usually gendered and gender is embedded in major social organisations such as health care (Lorber, 1997). Researchers find that gender makes a difference in two ways: women and men patients are treated differently, and women and men practitioners treat patients differently (for a review of the studies examining gender effects in medical encounters see Roter & Hall, 1997).

Gender affects the communication between patient and practitioner. Various studies (mainly of medical practitioners) show that female patients are given more information than males and the information is given in simpler language, that female patients ask more questions in general, and initiate more discussion after the doctor's explanation. Female patients receive more positive talk, and more attempts to include them in discussion, are asked more often than males about their feelings and/or opinions, and are more likely to ask for help. Female patients appear to be more emotionally engaged in the encounters than males; they disclose more emotional concerns and receive more empathy and reassurance. On the other hand, research shows that male patients are more likely to present their opinions or suggestions without prompting, and are likewise more likely than female patients to voice disagreement (see Roter & Hall, 1997).

The gender of the practitioner has major effects on the patient's experience of health care. Research suggests that generally female practitioners treat patients differently from male practitioners, and that patients (both male and female) talk more and seem to participate more actively in the encounter when the practitioner is female (Hall, Irish, Roter, Ehrlich & Miller, 1994; Lorber, 1997).

At a different level, women patients, who visit PHCPs more often than men, are treated less pro-actively with regard to certain health care conditions (e.g., heart disease), and women doctors are more likely to order cervical smear tests and mammograms for their female patients (Lorber, 1997). In these ways then, gender effects impact patients in the context of their relationship with practitioners, and thus play an important role in the way the patients experience health and illness.

Models of the Patient-Practitioner Relationship

Theorists have developed various models of the patient-practitioner relationship. These conceptualisations have developed in two waves, an earlier wave that was focused on patient relationships with medical practitioners (called the 'patient-doctor' or 'patient-physician' relationship), and a later wave, broader than the first, that explores the 'therapeutic' relationship between a patient and any health care practitioner (including but not restricted to medical practitioners). This literature has developed in conjunction with such research interests as medical sociology's inquiry into the dominance of biomedicine, the feminist focus on the power and control inherent in the professional health care relationship, and the nursing profession's engagement with the 'care vs. cure' debate.

It is useful to understand these different models as being theoretical positions on a relationship continuum. At one end of this continuum are patient-centred interactions that take a holistic approach to the health care of the patient, focusing as much on the 'care' aspects as the 'cure', and integrating all of the determinants of health according to the biopsychosocial perspective of health care and illness. At the other extreme of the theoretical continuum, are disease-centred interactions between patients and PHCPs that emphasise the practitioner's technical knowledge and skills, and focus on curing the symptoms of illness as presented in the patient's body, based on the biomedical paradigm of health care and illness.

The interaction between a patient and an archetypal biomedical practitioner can be regarded as typical of the disease-centred type of relationship. The doctor, male, makes the decisions for the patient (particularly women), discounts as subjective and unreliable the patient's personal data, restricts information about the patient's problem, and thus holds the power in the relationship (Goodyear-Smith & Buetow, 2001; Lorber, 1997). Relationships between complementary practitioners and patients are generally regarded as typical of the patient-centred model, because of their emphasis on the patient's holistic experience of health and illness. The practitioner takes a highly individualised approach to the treatment, and throughout the consultation (usually longer than a GP consultation – up to an hour for instance) seeks detailed personal information about the patient's health problem and its significance, relative to her/his lifeworld, before working with the patient to tailor the health care programme (Cant & Sharma, 2000; Frank, 2002).

In real life, of course, patient-practitioner relationships are not this simple. Research demonstrates that the contemporary health care relationship can change considerably over the course of a single encounter (Woodward, 1998), as well as over multiple encounters between the same individuals for a variety of health reasons (Walker et al., 2001). In other words, any one encounter can shift position on the relationship continuum as the patient and practitioner negotiate health care perspectives and needs, and their experiences of health and illness change.

These models of the patient-practitioner relationship define a conceptual space within which we can examine the roles prescribed for each individual; the models ‘set the stage’ for developing a deeper understanding of the roles of patient and of practitioner. The sociological notion of role enables us to connect the patient’s lived experience with the health care system, the prevailing discourses and bodies of knowledge framing health and illness, and the relational dynamics that develop between her/him and the practitioner. In the following discussion, because this research focuses on the patient’s perspective and experience of trust, I will train the spotlight on the patient and her/his role within the context of the therapeutic relationship.

Patient Models: The ‘Sick Role’

In the disease-centred relationship, the patient role is structured around passivity, deference to the doctor, and unquestioning compliance with prescribed treatment, which ultimately contribute to strengthening the patient’s dependence on the practitioner. These behaviours conform to the classical, biomedical ‘sick role’,

underpinned by the following socio-cultural assumptions regarding the 'right' behaviour for a sick person:

- the patient is obliged to try to get well,
- the patient is obliged to entrust their health to health care experts, and
- the patient is expected to obey the expert (Bates & Linder-Pelz, 1987).

This role was established and well-defined as the medical profession, afforded ever-increasing privilege and authority, became the dominant health care institution within Western society. The challenges to that domination have brought profound changes to the role of patient, as theorists and patients alike recognise the power and control imbalances entrenched in the biomedical patient role (Armstrong, 2000; Hardey, 1998).

Alternatives to the biomedical role have evolved as people have become informed and experienced in different ways of 'doing' health care. Each of these alternative patient roles is grounded in a particular discourse, or 'way of knowing' about health care, that is quite different from the dominant medical discourse. Along with the role sets, each discourse has its own culture, with a unique language, values, practices, and expectations. In particular, I wish to review two of these other roles, the patient as agent and the patient as consumer. These two role sets are commonly used by patients today as alternatives to the biomedical protocol for the relationship, and are therefore reasonably well developed. However, the fact remains that the role prescribed for the patient by biomedicine, remains the dominant and most preferred by contemporary patients (Cant & Sharma, 2000; Lupton, 2002; Nettleton & Gustafsson, 2002).

Patient Models: The Patient as Agent

Central to the behaviour norms and expectations for the patient interacting within patient-centred relationships (typical of complementary therapies) are notions of patient autonomy and agency, the holistic health paradigm, the importance of the patient's subjective health experiences, and awareness of the socio-cultural determinants of health. In this role set, the patient is expected to be an active collaborator in her/his health care; the patient shares the responsibilities inherent in the relationship for initiatory behaviour and decision-making (Robinson, 2003). The patient who adopts this role is sanctioned

- to volunteer personal information, opinions, and preferences,
- to ask questions, to ask for information, explanations, or clarification,
- to disagree with the practitioner,
- to express concerns, worries, and emotions,
- to gather and share information,
- to make decisions, and
- to take responsibility for the treatment outcomes (Robinson, 2003; Thakur & Perkel, 2002).

Thus, the patient who relates to the practitioner according to this role is expected to take much more personal responsibility for her/his health care within (and outside) the context of the relationship. The practitioner is expected to offer advice and knowledge that is guided by the patient's needs and values, and to relate to the patient in ways that foster dignity and respect (Thakur & Perkel, 2002).

Patient Models: The Patient as Consumer

This patient role, which relies on the twin ideologies of consumerism and individualism, supports the patient who looks out for and asserts her/his 'rights' as the customer of a health care practitioner. This consumer-patient is individualistic, questioning and assertive, resists dependency on the practitioner, and is generally well-informed and ready to challenge the practitioner's opinions (Lewis & Bridger, 2000; Lupton, 1996). In a medical context, for instance, patients who assume this role, are "willing and able to exercise choices about their doctors in the same way as they do about restaurants, hairdressers, or supermarkets" (R. Leavy, D. Wilkin, & D. Metcalfe, 1989 as cited in Lupton, 1996, p. 157).

This consumer-patient gathers information independently of the practitioner, from a range of sources, but particularly the Internet. Coile (2001) predicts that the 'wired' health care consumer, will drive patients' demands for the latest biomedical drugs and treatment. He believes that wired baby boomers are especially significant, and will become even more so as they begin to suffer chronic health care problems at the same time as they are managing the health needs of their children and aging parents. Baby boomers lead the way in surfing the Net for health care information and services, for example, researching online the side effects of a drug that a medical practitioner has prescribed.

This role upholds the rights of the patient, as a consumer, to quality health care delivered as a formal contractual obligation of the practitioner. These health care rights are recognised and detailed in the patient charters commonly found in clinic

waiting rooms and hospital corridors in New Zealand. The consumer-patient is fully aware of the competitive nature of the health care market, and is prepared to hold health care providers to account. The individual is aware also of the right to receive information and to discuss treatment benefits and alternatives, along with compassion and continuity of care.

Following this role, the patient will complain if the quality of health care does not meet expected standards and take her/his business elsewhere. Rather than acting as the compliant patient of the biomedical mold, this individual behaves as a concerned, informed consumer who exerts active control over personal health care (Annandale, 1998; Kelner & Wellman, 1997; Thakur & Perkel, 2002). This particular patient position is 'protected' and enhanced in the New Zealand health care context by patient advocates, informed consent, formalised complaints procedures, and the existence of the Health and Disability Commissioner.

Real Life Patients

The preceding relationship models and conceptualisations of the patient are, of course, abstractions. They afford us insight to the behaviour and organisation of the people involved in the patient-practitioner relationship, and thus enable us to better understand the dynamics of this inter-relation from a theoretical point of view. But they do not fully account for the lived experiences of contemporary patients.

In real life, people are not always this tidy or this simple. The patient-practitioner relationship can be an extremely complex, fluid interaction, moving between

different focuses and shaped by a diverse range of influences that come in and out of play during the same encounter. Contemporary theorists (e.g., Frank, 2002; Goodyear-Smith & Buetow, 2001; Lupton, 2002) believe that patients can move quite freely among the health care discourses and their associated roles, both between and within single encounters, according to their health care needs. (This 'shopping around' for health care providers and discourse-hopping suggest that these postmodern patients are becoming well educated and experienced in health care plurality.)

Kelner and Wellman (1997) show that patients, at times, deliberately choose different kinds of primary health care practitioners for particular problems, and sometimes will choose a mixture of treatments for the one problem. For example, patients can choose chiropractors for backaches, naturopaths for colds, and might consult both their GP and acupuncturist for skin disease. This flexibility implies that patients are comfortable moving between discourses and adopting different patient positions accordingly within these relationships.

The patient position we take during any single encounter with a PHCP can shift also. The position a patient adopts depends on a range of socio-cultural and individual personality factors, as well as on particular characteristics of the patient-practitioner relationship and of the specific health care situation they are in (see Deber, 1994). To illustrate, some individuals prefer to adopt the passive-dependent patient role in all their patient-practitioner relationships, and therefore to not take an active part in decision-making, because of psychological reasons (Babrow, Hines & Kasch, 2000; Rimal, 2001). Other individuals prefer to relate from the active patient position, but

adopt the passive role over the course of a severe illness or during instances of intense pain (Arora & McHorney, 2000; Steinhart, 2002). Once their immediate treatment or symptomatic needs are met then these patients take up the active role again in the relationship.

The wider socio-cultural contexts of health care also shape the dynamics of the interpersonal relationship. For example, no matter how well informed people might be, either on a particular health condition or on patient rights, they will continue to be at a disadvantage relative to medical practitioners for as long as the biomedical model and health systems are sanctioned by the State. Moreover, the experiential esoteric knowledge held by any health care practitioner ensures that patients are never fully equal in the relationship. Paradoxically, it is precisely because of this specialised knowledge and expertise that the patients have entered a relationship with the practitioners.

Finally, these models all seem to involve patients who are at least middle class, reasonably educated, and able to consciously negotiate their patient positions. They lose their meaningfulness in situations where the patients are considered to be 'socially disadvantaged' before they even enter a patient-practitioner relationship; for example, a Cook Island mother of seven, living in South Auckland, on the Domestic Purposes Benefit. Similarly, the models begin to unravel when patients are incapable of making sound decisions; for instance, when they are in pain, frightened, under medication, unconscious, traumatised, or in a foreign environment.

2.5 Implications in Context

Health care services share the fundamental characteristics of services – intangibility, variability, inseparability, perishability, and ownership (Bebko, 2000; France & Grover, 1992; Liljander, & Roos, 2002). Theorists also recognise that health care is markedly different from other consumer services. The following section will review the distinguishing characteristics of health care services and consider their implications for patients, the end consumers of health care.

Because of the common characteristics of their context(s) and the nature of the services themselves, health care services are high in search, experience, and credence qualities (Arnold, Hoffman, & McCormick, 1989; Mitra, Reiss, & Capella, 1999; Ostrom & Iacobucci, 1995; Zeithaml, 1981). This means that patients generally find it difficult to evaluate the attributes of a health care service prior to the consultation, and, indeed, even after the service encounter or course of health care treatment. Evaluation of the clinical dimension of the health care service (i.e., the ‘core’ health care product, being the practitioner’s clinical response to the patient’s illness, also commonly referred to as the ‘cure’ aspect) is particularly complex for the individual patient. Thus, health care services are also regarded as being characteristically high risk and high involvement purchases for the patient (see Gabbott & Hogg, 1998; Kotler & Bloom, 1984).

Uncertainty and Perceived Risk

Uncertainty is particularly high for patients. Despite the fact that patients are increasingly well informed and taking more control of their health care, they continually face major problems evaluating the health care offering both before and after purchase and consumption. Particularly for acute illnesses, patients frequently have little experiential knowledge, simply because they lack prior experience. For example, an individual with appendicitis generally will not have previous experience of the condition. Diagnoses and treatments can vary from one health care practitioner to the next, as can the skill and competence of practitioners within the same health care modality. In addition, because of individual physiological variability, patients can never be certain of treatment outcomes (Fox, 2000).

Patient uncertainty can be exacerbated by wider contextual factors such as the growing distrust of the medical profession, the move by patients to access expert health care information themselves, and the increasing use of complementary health care practitioners. Health care controversies and scandals serve to heighten public awareness that health care knowledge and practice is open to dispute and misuse. Certainly, information sourced from outside the patient-practitioner encounter means that the patient can be extremely well-informed; this empowers the patient to take a more active role in the patient-practitioner relationship (Annandale, 1998).

However, as some commentators (e.g., Gutierrez & Kendall, 2000; Nettleton & Gustafsson, 2002) point out, this knowledge also effectively widens the range of options from which the patient must choose, and thereby can increase patient

uncertainty and anxiety considerably. Experience using a range of different health care modalities could be seen to have the same effect; the more therapies used, the wider the range of choices, the greater the anxiety faced by the patient.

Uncertainty is directly linked to perceived risk in any service encounter (Mitra, Reiss & Capella, 1999; Wannop, 1989). The inherent characteristics of health care services and their contexts already discussed heighten uncertainty and perceived risk for patients (Crutchfield, 2001; Fox, 2000). Finally, underscoring these contextual and situational uncertainties is the knowledge that health care can involve ‘Life and Death’ decisions (at worst) or quality of life decisions (at best). By definition, when I am a patient it is my health that is at risk.

Trust in the Patient-Practitioner Relationship

Furthermore, high levels of uncertainty and perceived risk generate high levels of vulnerability and dependency in patients, and can also evoke intense feelings of ambivalence, dependence, and anxiety (Lupton, 1996). It is in conditions such as these that patients choose to trust – or not - their primary health care practitioners, because, as Cassell observes: “Trust in others is one of the central human solutions to the paralysis of unbearable uncertainty” (1991, p. 76). Trust reduces the patient’s perceived risk by substituting confidence in the expertise and control proffered by the practitioner. Thus, trust is a way of simplifying complexity and moving on, despite the insecurity caused by uncertainty in risky health circumstances. In this way then, trust acts to facilitate cooperation and healing in the health care context (Daniel, 1998).

Many health care authors acknowledge patient trust as a key component of the patient-practitioner relationship, and therefore of the patient's health (Balint & Shelton, 1996; Leopold, Cooper, & Clancy, 1996; Mechanic & Schlesinger, 1996; Thom & Campbell, 1997). Theorists and researchers from other disciplines, including marketing, likewise identify trust as a fundamental building block in relationship models. For instance, relationship marketing theorist Berry positions trust as "perhaps the single most powerful relationship marketing tool available" (2000, p. 164). These findings on the centrality of patient trust to their personal health and that of their relationship with their practitioners underscores the importance of understanding how they live it in practice.

2.6 Concluding Comments

This chapter has examined the complex interactions between the nest of contexts in which an individual's experience of health care is situated. A deep understanding of patients' experiences of trust must be based on understanding the influence within the patient-practitioner relationship of social forces and constraints from the global and national contexts of health care - one without the other would only give us a partial view of patient trust. The next chapter will review existing knowledges of the phenomenon of trust, particularly as it is understood within the marketing discipline, in order to explore the connections between trust and gender, in a health care context.

2.7 In My Own Words

Interesting chapter this one – a very ‘heady’ experience. Involved head-stuff almost exclusively. For a while I thought that there was nothing to reflect upon. But looking back over the time it’s taken to write, I notice with interest that during this chapter my head hurt a lot – migraines and disturbed sleep. I notice too that over this time I have set consciously into our domestic routine activities that I have needed to maintain some sort of balance between head and heart and soul – to stay healthy and happy. Much walking, regular meditating, and planned contact with family and friends. Have had to consciously work to make sure that my children and I get some fun family time together (no PhD every second weekend, video-and-chips Fri. night; house-work Sat. morning, full-on socialising afternoon and evening; special trip out of Hamilton on Sun. – bush-walking, swimming, exploring). I think of this time as our re-bonding time, time to refresh our hearts together.

Interesting parallels too between my experience with this ‘head’ chapter and dominant discourses in society that focus on one aspect of the human being to the exclusion of the other dimensions, for instance the positivist discourse of the university, and the biomedical discourse of health care. Both discourses celebrate the head-stuff, a focus that we are now beginning to understand needs to be balanced in order to keep people happy and healthy i.e., not dis-eased.

In terms of the research process, this chapter has challenged me to be disciplined in my daily work habits (butt on board) and the way I organised the materials I used to understand the contexts of health care. Huge amount of material out there and lots of

wonderful little side-paths leading off and away from the True Path. Mea culpa. (Also notice that at times I'm talking like a journal article. Trust this condition will run its course.)

Two exciting confirmations in this chapter time. First, the decision to use primary health care practitioners instead of only GPs means the study is a much better reflection of the ways we as patients are managing our health care these days, in that people are choosing a range of practitioners to meet their health care needs. Second, have come across theorists who are articulating what was well-developed in me as an 'intuition' about our health care patterns but about which I was struggling to speak coherently. (These include the ideas of competing/conflicting discourses about health and illness, and therefore health care; and 'multi-faceted' postmodern patients.) Am confident that these theorists will help me to express and extend the participants' work.

3: Concepts and Connections

“If any recognizable entity or form of relationship can be related to any other, then the landscape of possibilities for understanding any action is without horizon”
(McNamee & Gergen, 1999, p.17).

3.1 Introduction

This research focuses on trust and gender. Through the social constructionist lens both can be seen as social phenomena (De Wulf, Odekerken-Schroder & Iacobucci, 2001). Neither trust nor gender can exist in isolation – an individual experiences both relative to other people. Both are regarded as complex, multi-faceted phenomena that are culturally and historically dependent (e.g., Jones & George, 1998; Lewicki, McAllister, & Bies, 1998). Due to the dynamic nature of the modern environments in which individuals experience trust and gender we should not be surprised therefore to hear some theorists concluding that both phenomena are difficult to ‘capture’ conceptually (e.g., Doney, Cannon, & Mullen, 1998). There has been considerable academic interest in trust and in gender, separately, over the past few decades, and a vigorous literature has grown around each.

This chapter reviews the literatures on trust and on gender, in order, firstly, to sketch a conceptual framework for understanding and extending the participants’ work on their experiences of the phenomena within their health care relationships, and secondly, in order to locate this research study within the existing literature. Relevant elements of the existing literatures on trust and gender will be used more extensively in Chapter 8,

as the bases for developing the data of this research. The overarching aim of surveying the literature at this stage in the research process is to enhance “theoretical sensitivity” (Strauss & Corbin, 1990, p. 51) so that, as the researcher, I am sensitive to what to look for in the participants’ work, and able to recognise connections and contributions from their data to established theory.

Accordingly, this survey is organised into three main sections. The first section, focused on trust, concentrates on the trust literature relating to relationship marketing, then discusses trust as it is understood in the health care literature, particularly that on the patient-practitioner relationship. The second section of the chapter addresses the literature on gender, particularly as gender is understood in the patient-practitioner interaction. The final section surveys the research that examines the intersection of trust and gender in the primary health care context.

Social constructionism is the theoretical lens through which I view these literatures, as well as the participants’ data, with the aim of recognising interconnections that might inform our understanding of their trust experiences. Both trust and gender are social experiences in that they are lived in relation to others - rather than being lone rational individual activities - and mediated through all the social, cultural, and political processes of life. Trust, like any other social phenomenon, must be gendered, because gender is one of the most important and powerful social statuses in any society (Lorber, 1997).

Therefore, given the social nature of both trust and gender, social constructionism provides both an appropriate and a promising theoretical platform for this research.

Social constructionism is concerned with the dialectical relationship between the individual and society (Annandale, 1998; Shotter, 1993) and the common-sense understandings, or versions of knowledge, that individuals construct in their daily social interactions (Schwandt, 2000). Social constructionism holds that “not only do we constitute (make) and reconstitute (remake) our own social worlds, but we are also ourselves made and remade by them in the process” (Shotter, 1993, p. 13). From a constructionist point of view then, ‘trust’ and ‘gender’ are experiences that acquire their meaning in mutual relating with others, in relationships that have their own social patterns and traditions and which, in turn, are lived against the backdrop of social practices prevailing in the wider historical, sociocultural context (Gergen, 2001).

The focus by social constructionism on interaction and social practices (Burr, 1995) brings it into alignment with the focuses of this research on the participants’ lived experiences of trust in their interactions with primary health care practitioners, and how their constructions of trust are bound up with the social practice(s) of gender. Social constructionism also fits naturally with the method chosen for this research, Memory Work, originally designed to explore issues of female genderisation and its relation to broader processes of socialisation as the particular social process of interest (Ingleton, 2000. See also Chapters 4 and 5 for discussion of links between social constructionism and method).

Social constructionism thus provides a theoretical framework that supports the movement in this research between the levels of individual self, the relationship, and the social in our attempts to grasp the meanings of patient trust constructed by

participants, and recognise the patterns among their individual experiences. Finally, a relational perspective has developed within social constructionism over the last decade, led by theorists such as Hosking, Dachler, Gergen, and McNamee, that centres on the relatedness of human life, in particular on the primacy of relationship in the construction of meaning. Experience both of ‘trust’ and of ‘gender’ in a relational sense are understood to be part of what is going on in any social relational process. Constructing the meaning of each thus is an ongoing process of relating (Dachler & Hosking, 1995). This perspective, which sharpens our understanding of knowledge as a relational endeavour, is particularly relevant to this research and adds extra theoretical strength to the social constructionist approach.

3.2 Trust

Trust is recognised widely as a key to successful human relations. Across the social science disciplines generally, scholars and researchers have examined it relative to contemporary society (e.g., Fukuyama, 1995), social systems (e.g., Luhmann, 1979), economic exchange (Arrow, 1974), and psychology (e.g., Deutsch, 1962). Informed by such studies, marketing theorists have developed the notion of trust as a concept central to exchange relationships (e.g., Anderson & Narus, 1990; Dwyer, Schurr & Oh, 1987; Frazier & Sheth, 1985; Sirdeshmukh, Singh, & Sabol, 2002).

Trust has received a great deal of attention within services marketing because of its critical links to customer satisfaction and service quality, and thence to customer loyalty and retention. Trust is particularly important in the context of credence-based services, where customers typically face considerable uncertainty due to inherent service characteristics (e.g., intangibility, complexity, high consequentiality and

involvement, and high interdependence) and subsequently perceive high levels of risk. In these types of service situations trust becomes increasingly significant to the customer because of the potential for service failure and negative outcomes (Crutchfield, 2001). Indeed, customer vulnerability is believed by some contemporary researchers (Bigley & Pearce, 1998; Singh & Sirdeshmukh, 2000) to be the main driver of trust in credence-based services.

Trust and Relationship Marketing

The literature associated with relationship marketing (RM), focussed on building successful and productive relationships within services, holds that trust is fundamental to developing and sustaining such relationships. Conceptual theorists (e.g., Berry, 2000; Gundlach & Murphy, 1993; Nooteboom, Berger & Noorderhaven, 1997) and empirical researchers (e.g., Brashear, Bellenger, & Brooks, 2003; Garbarino & Johnson, 1999; Tax, Brown, & Chandrashekar, 1998; Verhoef, Franses, & Hoekstra, 2002) link trust directly to commitment. Other key research in the relationship marketing field links trust to customer satisfaction (e.g., Gwinner, Gremler, & Bitner, 1998; Ranaweera & Prabhu, 2003), customer loyalty (e.g., Morgan & Hunt, 1994; Singh & Sirdeshmukh, 2000), cooperation (e.g., Berry, 1999; Morgan & Hunt, 1994), and retention (e.g., Crutchfield, 2001; Reichfield & Scheffer, 2000).

Definitions of Trust

Within the relationship marketing literature there is a wide range of different definitions of trust. Of these, five definitions in particular have been frequently

adopted (or adapted) by researchers trying either to build trust or relational theory, or to operationalise the trust concept. These commonly-found definitions of trust are:

- Trust exists “when one party has confidence in an exchange partner’s reliability and integrity” (Morgan & Hunt, 1994, p. 23).
- Trust is “the firm’s belief that another company will perform actions that will result in positive actions for the firm, as well as not take unexpected actions that would result in negative outcomes for the firm” (Anderson & Narus, 1990, p. 45).
- Trust is “the willingness of a party to rely on the behaviours of others, especially when these behaviours have outcome implications for the party bestowing trust” (Andaleeb, 1996, p. 79).
- Trust is “one party’s belief that its needs will be fulfilled in future by actions taken by the other party” (Anderson & Weitz, 1989, p. 312).
- Trust is “the belief that a partner’s word or promise is reliable and a party will fulfil his/her obligation in the relationship” (Schurr & Ozanne, 1985, p. 40).

These five definitions are included in a comprehensive list of 16 different definitions of trust compiled for a meta-analysis of the relationship marketing literature. Scholars O’Malley and Tynan (1997) identify six elements commonly used by the relationship marketing theorists to conceptualise trust. These elements continue to be used by more recent theorists. Applied to a customer-provider relationship, the common elements are:

1. A certain positive belief or expectation held by the customer. ‘Belief’ or ‘expectation’ is mentioned explicitly in many definitions, for example: “Trust is...the specific expectation the another’s actions will be beneficial rather than detrimental” (Creed & Miles, 1996, p. 17). Theorists also refer to this as a

confidence (e.g., Garbarino & Johnson, 1999); more particularly, a confidence that the provider is benevolent and honest (e.g., Nicholson, Compeau, & Sethi, 2001).

2. The provider's motives and intentions have integrity. O'Malley and Tynan use the phrase "integrity of intent" (p. 493) to encapsulate expressions among the trust definitions such as "a party's word or promise is reliable" (Schurr & Ozanne, 1985, p. 40).
3. The provider will behave with integrity. This element, termed "integrity of behaviour" (p. 495), encompasses expressions within the definitions such as "not take unexpected actions that would result in negative outcomes" (Anderson & Narus, 1990, p. 40) that the provider will not exploit the customer's vulnerability (Dwyer & Oh, 1987). Also, the other's "abilities, expertise and knowledge" (Wilson & Moller, 1995, p. 57) are included in this element, and, in turn, relate to the provider's credibility (Ganesan, 1994).
4. The customer's needs will be fulfilled, as articulated in the Anderson and Weitz definition: "One party believes that its needs will be fulfilled..." (1990, p. 312). Other theorists extend this aspect to include valence; more specifically, the individual expects that the payoffs will be positive (Bhattacharya, Devinney & Pillutla, 1998; Parkhe & Miller, 2000).
5. The customer will not experience negative outcomes as a result of the provider's behaviour. This refers to the notion that the other party's actions will be "at least not detrimental" (Bradach & Eccles, 1989, p. 104).
6. A long-term orientation to the customer-provider exchange, reflected in the definitions by such phrases as "the long-term interests of the customer" (Crosby, Evans, & Cowles, 1990, p. 70).

O'Malley and Tynan's scheme, like similar schemes from other disciplines that attempt to identify the common elements of trust, is a useful beginning point for conceptually dealing with the diverse collection of definitions. However, at times the scheme appears a little unwieldy and inconsistent. It is likely that some of the difficulties of the O'Malley and Tynan scheme can be accounted for simply by recognising the definitions refer to trust that occurs in distinctly different relationship contexts. For instance, the trust definition articulated by Crosby, Evans, and Cowles (1990, p. 70) is situated in the customer-salesperson interaction (i.e., interpersonal trust), while Anderson and Narus (1990, p. 45) define trust in a firm-to-firm relationship context (i.e., inter-firm trust).

In comparison, Swan, Bowers, and Richardson (1999) limit their meta-analysis to empirical RM studies that define customer trust in a salesperson specifically. From their analysis of 16 articles that qualified for inclusion, the authors refine the commonalities to three elements. These are:

1. The salesperson's competence, which includes "skills, expertise, and ability such that information provided by the salesperson is valid and reliable" (p. 94),
2. The salesperson's benevolence, or "motivation to protect the customer's interests" (p. 94), and
3. Perceived risk, in so far as "the relevance of trust increases as risk to the [customer] of the failure of the salesperson to be trustworthy increases" (p.94).

More recent definitions of trust from the relationship marketing literature tend to be composites of several earlier seminal definitions, and naturally refer to many of the

common elements either explicitly or implicitly. For example, the definition of trust framed by Delgado-Ballester and Munuera-Aleman (2001) for an empirical investigation of brand trust, describes trust within a marketing relationship as follows:

Trust in a person is a feeling of security based on the belief that his/her behaviour is guided and motivated by favourable and positive intentions towards the welfare and interests of his/her partner. Therefore, it is expected that he/she does not intend to lie, break promises or take advantage of the other's vulnerability. Therefore, the lesser the doubt that his/her purposes are questionable, the lesser the risk to the relationship and, so, the development of a valuable relationship will be less difficult (p. 1242).

Or this definition of trust from the management literature, used in a conceptual study:

“Trust is an expectancy of positive (or non-negative) outcomes that one can receive based on the expected action of another party in an interaction characterized by uncertainty” (Bhattacharya, Divinney, & Pillutla, 1998, p. 462).

It is important to note that the previous definitions and conceptualisations of trust take a very objective view of the phenomenon. Even when emotion is implied (e.g., by the word “feeling” in the Delgado-Ballester and Munuera-Aleman definition above), they have a marked positivist tone to them; the focus is on the trustor and trustee as separate entities within the relationship, and the experience of trust is presented as predominantly cognitive in nature.

Trust Themes in the Literature

As the previous definitions illustrate, theorists approach the study of trust from different perspectives and concentrate on different aspects of the phenomenon.

Overall, there are six distinct focuses evident within the marketing literature on trust:

studies that focus on the bases of trust, antecedents of trust, types of trust, processes of trust development, dimensions of trust, or outcomes of trust. These focuses, presented here more generally as themes, provide a useful framework for organising the marketing literature on trust.

Bases of Trust

Ali and Birley (1998), applying Zucker's conceptualisations (1986), contend that trust that occurs within a marketing relationship (specifically, between a customer and a marketing entrepreneur) is either institution-based or individual-based. Institution-based trust is tied to governance mechanisms, such as those maintained by professional governance bodies, that serve to uphold reliable discreet behaviour (see Sheppard & Sherman, 1998). In the context of this research, for instance, trust would have an institution base if a patient previously had not met the doctor treating her/him for an injury in the local medical centre. In this case, according to the Ali and Birley scheme, the patient's trust in the doctor would be based on the trust s/he has (1) in the medical centre itself; and/or (2) in the New Zealand health care system; and/or (3) in the medical profession as a whole.

Individual-based trust, on the other hand, is linked directly to the individual, either to inherent characteristics (characteristic-based trust), or to previous behaviour (process-based trust). Characteristic-based trust is distinguished from process-based trust by a distinctive cognitive factor. It occurs when the customer perceives a social similarity with the provider; for example, the patient might consider the ethnic background of the emergency doctor to be a critical factor in their interaction. Process-based trust

develops as both individuals ‘prove’ their trustworthiness in a series of interactions over time, therefore is firmly anchored in past experience of the other person. So, the patient’s trust would be process-based if the doctor who was available to treat the emergency injury was the practitioner whom the patient had been ‘seeing’ regularly for most health care needs over the past seven years, for instance.

Antecedents of Trust

Vulnerability and perceived risk are acknowledged as major antecedents of trust by theorists (e.g., Andaleeb, 1992; Sitkin & Weingert, 1995). Perceived risk occurs in certain situations where the customer faces uncertainty or ambiguity, and is therefore vulnerable to some degree (Doney, Cannon, & Mullen, 1998). Risk and vulnerability are both closely associated with market relationships where the outcomes of a customer’s decisions are uncertain and consequential (Dowling & Staelin, 1994). Thus, in a health care context, where information is often imperfect, outcomes are uncertain and highly involving for the patient, the level of inherent risk can be perceived as extremely high by the patient. Together, these situational factors create the antecedent conditions for trust to occur in the relationship.

Indeed, it has been argued that trust is only relevant in risky situations – if there is no risk there is no need for trust – and to trust means to take a risk, and leave yourself vulnerable to the behaviour of the person you trust (see Das & Teng, 1998). Thus, trust is both possible and important in contexts of risk. Trust is a coping mechanism – as risk and dependence increase so too does the importance of trust (Wicks, Berman, & Jones, 1999). The interdependency that arises in a risky context is a concept that

marketing theorists have noted: “Trust is an interdependent relationship, when one of the partners has to engage without being sure of the outcome” (Gurvitz, 1997, p. 508). In this way then, the outcome for the customer is dependent on the behaviour of the provider.

Especially relevant then for marketing interactions perceived as inherently uncertain or risky, is the research that finds that customer trust is influenced by factors such as the frequency of interactions (e.g., Doney & Cannon, 1997), perceived social similarity (e.g., Morgan & Hunt, 1994), the communication between the two individuals, and the relative power of each (e.g., Ali & Birley, 1998; Crosby, Evans & Cowles, 1990; Doney & Cannon, 1997; Morgan & Hunt, 1994; Smith & Barclay, 1997; Young & Wilkinson, 1989). Other antecedents of trust relate to the specific individual, and are perceived as the other person’s ‘trustworthiness’. These include the other’s expertise, competence, customer-orientation, dependability, honesty, and likeability (Hawes, Mast, & Swan, 1989; Nicholson, Compeau, & Sethi, 2001).

In a health care context that is experienced as complex and uncertain by the patient, then, trust functions to reduce that complexity and uncertainty “by allowing specific undesirable conduct to be removed from consideration (simplification of the decision tree) and by allowing desirable conduct to be seen as certain” (Lewicki, McAllister & Bies, 1998, p. 444).

Types of Trust

Studies on trust conceptualise it either as a global, generalised phenomenon, or distinguish different types or forms of trust. Contemporary researchers Nicholson, Compeau and Sethi (2001), for instance, theorise trust as a singular, generalised construct, in the tradition of Doney and Cannon (1997) and Morgan and Hunt (1994). It is common, for researchers who take this approach, to represent trust as a generalised state, feeling, or attitude (e.g., Young & Wilkinson, 1989) that is experienced in varying strengths, and thence to distinguish different levels of trust (e.g., Barney & Hansen, 1994; Schurr & Ozanne, 1985). To illustrate, Barney and Hansen model three levels of trust: weak trust, semi-strong trust, or strong trust, with strong-level trust an ideal source of competitive advantage. According to these researchers the level of trust that occurs in an economic exchange relationship is determined by salient situational factors (e.g., inherent uncertainty).

In contrast, another group of trust studies detail different kinds of trust. One such typology proposes five types of trust: calculative, verifiable, reciprocal, earned, and blind trust, distinguished on the ethical foundation of each type (Murphy & Gundlach, 1997). These authors contend that earned and reciprocal trusts are intrinsically preferable to the other trust forms. In a health care context, earned and reciprocal trust would relate to, respectively, trust that reflects a certain confidence in the primary health care practitioner that the patient has acquired from past experience with the practitioner, and trust that is shared jointly between the patient and practitioner in relationship.

Andaleeb (1992) theorises four categories of trust that occur in an exchange relationship. ‘Bonding trust’, characterised by mutual confidence and commitment to continue the relationship, results in a high-quality, stable relationship. ‘Hopeful trust’ contains some doubt about the provider’s competence (the ability to produce desired outcomes), although the customer is prepared to continue the relationship – hopeful that things will improve. The third type of trust is ‘unstable trust’, and accounts for those trust circumstances where the customer questions the provider’s motives, but does not doubt the provider’s competence. ‘Distrust’ is the state in which the customer has negative perceptions about both the competence and the intentions of the provider.

Regardless of whether they treat trust as a general construct or as distinctive types, theorists commonly place the different levels or forms of trust along a theoretical continuum. Thus, trust ranges from weak to strong trust for Barney & Hansen (1994), while calculative trust and blind trust are the implied extreme points in the Murphy and Gundlach (1997) scheme. Bonding trust and distrust are the extreme points in the Andaleeb scheme.

Scholars now propose that this continuum, articulated as a ‘band’ of trust, has both breadth and width, which are determined by the interaction of the key trust factors operating for particular individuals at a particular time over the course of a relationship (e.g., Lewicki, McAllister, & Bies, 1998; Rousseau, Sitkin, Burt, & Camerer, 1998; Sheppard & Sherman, 1998). This encourages a deeper understanding of trust as a dynamic phenomenon, which can be recognised in different forms along the band, while at the same time fluctuating in terms of depth.

Dimensions of Trust

The discussion of different forms of trust leads naturally into considering the dimensions of the trust phenomenon, as they are understood by marketing scholars. Again, there is a wide, and at times confusing, range of work on this aspect of trust. In the interests of managing this diversity, and for the purpose of this research, I organise the work according to whether the conceptualised dimension applies mainly to the customer/patient, to the provider/practitioner, or to dyad/patient-practitioner relationship itself.

The dimensions of trust that centre on the individual customer experiencing the trust are commonly referred to as the cognitive, affective, and behavioural (sometimes called 'conative') dimensions. The cognitive dimension to trust has been the most frequently studied of the three dimensions. The affective dimension was relatively neglected until recently, but is being explored more thoroughly as scholars from across many disciplines, including marketing, acknowledge the importance of the emotions to human experience. Currently, the behavioural dimension is an under-researched topic, although it is implied or alluded to in many studies on trust, notably those that refer to the 'willingness' to rely on the other party in a relationship (e.g., Andaleeb, 1992; Moorman, Zaltman, & Deshpande, 1992; Nicholson et al., 2001; Smith & Barclay, 1997).

This section outlines the cognitive, affective, and behavioural dimensions of trust. It must be noted also that some scholars are beginning to explore a moral, or ethical, dimension to trust which involves notions of values, fairness, equity, and justice (e.g.,

Brenkert, 1998; Gurviez, 1997; Iverson, McLeod, & Erwin, 1996; Jones & George, 1998) but because this dimension is not generally acknowledged by theorists nor well-established in the literature, it will not be reviewed here in any depth.

The cognitive dimension relies on the customer's "rational evaluation of another's ability to carry out obligations" (Jeffries & Reed, 2000). Thus, the individual decides whether or not to trust the other person, based on a cognitive appraisal of evidence of their 'trustworthiness' (Hupcey, Penrod, Morse, & Mitcham, 2001; McAllister, 1995). This rational evaluation ranges across such qualities in the other person as consistency, competence, honesty, fairness, helpfulness, and benevolence (e.g., Andaleeb, 1994; Zineldin & Jonsson, 2000). The concept of trustworthiness, integral to this cognitive dimension of trust, will be discussed further shortly in this chapter. Finally, the cognitive appraisal of the other person's trustworthiness is shaped by certain dispositional characteristics of the individual such as uncertainty orientation (Sorrentino, Holmes, & Hanna, 1995), power-distance orientation (Lee, Pillutla, & Law, 2000), and/or trust-suspicion predisposition (Shaub, 1996).

The affective dimension of trust is founded on the emotional bonds between the two people. It relates to the emotional investment the customer makes both in the provider and in their relationship, and results in an emotional security for the individual (Jeffries & Reed, 2000; McAllister, 1995). This dimension embraces the emotions and moods that arise in the individual as part of the total trust experience, the influence of affect on the person's trust experience, and the emotional component of the expectations underlying trust (Jones & George, 1998).

The emotional dimension to trust would be evidenced, for instance, in a patient feeling intense fear and anxiety at the beginning of a consultation; a patient feeling reassured, confident, relaxed, hopeful in the presence of the practitioner; and a patient feeling intense emotional outrage around negative experiences of trust e.g., a violation of trust by the practitioner.

The third dimension of trust commonly found in the literature is the behavioural (or conative) dimension. The behavioural component of trust theorises the customer's willingness to accept vulnerability in the face of uncertainty (Smith & Barclay, 1997), and engage in risk-taking behaviour, confident that the provider will behave competently and benevolently (Ali & Birley, 1998; De Wulf, Odekerken-Schroder, & Iacobucci, 2001; Zineldin & Jonsson, 2000). In other words, patients live the behavioural dimension to trust when they act as if the uncertain future actions of their practitioners are actually certain in circumstances when the result of a violation of their trust would cause serious negative health consequences for those patients.

A second group of work in the literature addresses as 'dimensions' of trust those aspects of the phenomenon that are focussed on the other person in the dyad, that is, the service provider or the primary health care practitioner in this research. These dimensions are either examined as general aspects of a global trust construct, or presented as aspects that demonstrate the 'trustworthiness' of the other person. Included in this group then, are the perceived attributes and behaviour of the provider, labelled in the literature as competence, benevolence, and credibility.

- **Competence:** The dimension of competence covers such attributes of the provider as qualifications, experience, specialised knowledge, skills and expertise of the provider, insofar as the provider can be depended on to provide technically competent service (e.g., Andaleeb, 1992; Swan, Bowers, & Richardson, 1999). Several theorists stress the fundamental importance of this dimension, holding that trust actually derives from the expectation of technically competent services (Andaleeb, 1992; Oakes, 1990). When the provider is perceived to be competent, the customer subsequently develops expectations in the provider that the desired outcomes are likely. The competence dimension is also the source of ‘expert’ power (Andaleeb, 1992).
- **Benevolence:** This dimension focuses on the perceived motives and intentions of the provider. More specifically, ‘benevolence’ includes the service provider showing sensitive consideration for the needs and interests of the consumer, and acting consistently in a way that protects these interests. Benevolence also reflects the customer’s confidence that the service provider can be relied on to act consistently and not take opportunistic advantage of the former’s vulnerability now, or in future dealings (Andaleeb, 1992; Atuahene-Gima & Li, 2002; Delgado-Ballester & Munuera-Aleman, 2001; Ganesan, 1994; Iverson, McLeod, & Erwin, 1996; Roberts, Varki, & Brodie, 2003; Smith & Barclay, 1997). Young and Wilkinson develop this dimension as the customer’s expectation of the provider’s “fiduciary responsibility” (1989, p. 114), stressing the customer’s confidence that at certain crucial times in the relationship the provider will put customer’s interests above her/his own.

- **Credibility:** The dimension of credibility is related to the expectancy that the provider's word can be relied on, that s/he is sincere, and that s/he will perform their role effectively and reliably. Thus, it centres on assessing the provider's integrity, reliability, and honesty (Ganesan 1994; Kumar, Scheer, & Steenkamp, 1995; Roberts et al., 2003; Smith & Barclay, 1997).

The third group of trust facets apparent in the literature can be made up of aspects that can be conceived as a property of the relationship itself, rather than characteristics of either the customer or the provider taken individually. These relational aspects, presently scattered throughout the literature, constitute an important dimension of the trust experience that is under-researched and generally unrecognised by marketing scholars. This grouping, which we can usefully call the 'relational dimension' of trust, provides a productive conceptual gathering-place for facets that seem to have been awkward to situate previously.

The 'relational dimension' thus amalgamates aspects of the trust experience such as shared feelings of common purpose and interest, and perceived shared values (Gurviez, 1997, Jeffries & Reed, 2000); co-ordinated behaviour toward a common goal (Andaleeb, 1992); a characteristic ability to deal to problems directly rather than degenerating into interpersonal conflict when problems arise (Lewicki, McAllister, & Bies, 1998; Morgan & Hunt, 1994); mutual concern for well-being and emotional attachment (Jeffries & Reed, 2000), expressed by Andaleeb as "psychological safety" (1992, p. 12). Smith and Barclay (1997) extend this notion of safety in their conceptualisation of trust: "Being able to rely on the competence and character of a partner provides a safe environment for investing in that relationship" (p. 16). The

sense of security in the relationship makes it safe for the individual to commit to continuing it (Crutchfield, 2001; Liljander & Strandvik, 1995; Morgan & Hunt, 1994).

Relational dynamics such as these engender a shared appreciation that the relationship itself is intrinsically valuable (Jeffries & Reed, 2000), and give the relationship a distinctive flexibility and responsiveness that enables it to adapt efficiently and effectively to new tasks and new customer needs (Iverson et al, 1996). Finally, the relational dimension of trust could have important implications for the individual's empowerment and future independence (literally, 'non dependence'). Indeed, some theorists argue that individuals who are in a trusting relationship might be more motivated to keep dependence on the other to a minimum, demonstrated in their careful use of scarce resources and investment in other dyadic relationships to have their needs met (Smith & Barclay, 1997).

Trust Development

In the RM literature, most authors present trust as a phenomenon that develops and builds in a relationship over time, linking evolving trust to increasing interaction and relational experience with the partner (e.g., Anderson & Weitz, 1989; Delgado-Ballester & Munuera-Aleman, 2001; Doney & Cannon, 1997; Dwyer, Schurr & Oh, 1987; Raval & Gronroos, 1996). The process of trust is thus generally conceptualised as cumulative.

Some researchers suggest that as trust evolves, there are fundamental changes in its nature corresponding to the maturation stage of the relationship (Nicholson,

Compeau, & Sethi, 2001; Swan, Bowers & Richardson, 1999). For instance, the trust between a patient and practitioner who have been working together for a year is going to be different from that experienced in a patient-practitioner relationship spanning many years. In the shorter relationship, Nicholson et al. propose that trust is most likely to be cognition-based, but as the patient and practitioner get to know each other better over time this trust usually changes into a form of trust that is affect-based.

In an early model of the trust process, Zaltman and Moorman (1988) posit three general developmental stages. First there is an interpersonal state defined by the extent to which the patient and practitioner can predict one another's behaviour; next, a dependence on one another when it counts; and finally, the patient has faith that the practitioner will continue to be responsive to her/his changing needs in the future.

Doney and Cannon (1997) identify five distinct processes by which trust can develop within a business relationship. Applied to the patient-primary health care practitioner dyad, this model proposes that the patient, for example, could develop trust in the practitioner by using a calculative process, a prediction process, a capability process, an intentionality process, or a transference process. The authors suggest that in any single encounter customers are likely to rely on more than one process to check their willingness to place themselves at risk (Doney & Cannon, 1997; Doney, Cannon, & Mullen, 1998).

It must be noted that these five are all cognitive processes, based on different cognitive analyses by the customer of particular provider behaviours. While the authors link these cognitive processes directly to behaviour in their contention that

each trust-building process depends on certain behavioural assumptions being met, they do not account for the role of affect in their model. However, research is beginning to incorporate the three individual-related dimensions of trust (cognitive, affective, behavioural) in discussions of trust development (e.g., Nicholson, Compeau, & Sethi, 2001; Swan, Bowers & Richardson, 1999) and thus allow for a more sophisticated understanding of the individual's trust experiences.

Another of the problems with the models of trust that present trust development as a general evolutionary process within a relationship, is the implication that trust levels start low and gradually increase over time. Theorising that posits low levels of trust at the beginning of a relationship does not explain those service encounters in which customers experience high levels of trust in a provider that they have never met before. A common example of this kind of encounter in the health care context is a health care crisis where the patient places great trust in the attending emergency practitioner. Such trust, referred to in the RM literature as “high initial trust” (McKnight, Cummings, & Chervany, 1998, p.473), and elsewhere as “swift trust” (Meyerson, Weick, & Kramer, 1996, p. 166), “blind trust” (Achrol, 1997, p. 66), and “faith” (Atuahene-Gima & Li, 2002, p. 62), is another aspect of the trust phenomenon with important implications for health care relationships that is neither well-researched nor well-understood within the RM literature.

Outcomes of Trust

The positive outcomes of trust are well-documented. For the individual customer, the important psychological benefits of trust in a partner are the reduction of stress and

anxiety (Sweeney & Webb, 2002). For the relationship itself, trust leads to improved communication, cooperation, and satisfaction, and thus to better relational quality overall (e.g., Anderson & Narus, 1990; Doney & Cannon, 1997; Mohr & Nevin, 1990; Nicholson, Compeau, & Sethi, 2001). Strategists realise that the trust inherent in a successful business relationship cannot be easily duplicated by competitors, thus the commercial value of trust lies in its ability to provide a sustainable competitive advantage to the service firm (Lewicki, McAllister, & Bies, 1998; Roberts, Varki, & Brodie, 2003).

Negative Trust Experiences

The early RM research conceptualised distrust and trust as separate and opposite constructs, often posited as the extremes of a trust continuum (e.g., Andaleeb, 1992). More recently, researchers across the disciplines have argued that trust and distrust are separate but linked phenomena (e.g., Jeffries & Reed, 2000; Lagace & Gassenheimer, 1991; Lewicki et al., 1998). Lewicki et al. hold that trust and distrust frequently occur simultaneously within relationships:

There are elements that contribute to the growth and decline of trust, and there are elements that contribute to the growth and decline of distrust. These elements grow and develop through an individual's experiences with another in the various facet-specific transactions of multiplex relations. Although broad, generalized inferences across the links may occur (i.e., strong levels of trust in some elements may generalize to create lower levels of distrust in others, and vice versa), it is possible for parties to both trust and distrust one another, given different experiences within the various facets of complex interpersonal relationships (p. 440).

As well as challenging the traditional polar positioning of trust and distrust, these authors also explore the common normative view of trust as 'good' and distrust as

‘bad’. Instead, Lewicki et al. argue that, like trust, distrust serves to reduce social complexity in that an individual perceives undesirable behaviour from another as likely, which in turn enables the individual to take protective action based on those expectations.

Other references to negative trust experiences in the RM literature include the “abuse” of trust (Atuahene-Gima & Li, 2002, p. 61), “betrayals” of trust (Elangovan & Shapiro, 1998, p. 547), “mistrust” (Swan et al., 1999), and “broken” trust (Nicholson et al., 2001, p. 12), but it appears that there has not been any attempt to distinguish theoretically between these experiences or model how they interact as constructs. However, there is growing interest in the broad topic of unrest and dissolution in commercial relationships (e.g., Good & Evans, 2001; Hocutt, 1998; Seiders & Berry, 1998), so it is likely that closer examination of negative trust experiences will be on future research agendas.

Measurement of Trust

‘Capturing’ the trust phenomenon and measuring it is not a straightforward exercise. Researchers have approached the task with a range of empirical designs, ranging from a simple question asking just how much the customer trusts another person or organisation (e.g., De Wulf, Odekerken-Schroder, & Iacobucci, 2001) to an 11-item scale designed to reflect four facets of trust: reliability/dependability, integrity/honesty, responsibility, and confidence (Wong & Sohal, 2002).

In their meta-analysis of the trust literature, Swan, Bowers and Richardson (1999) identify three levels of trust measures. Some measures focus on particular behaviours of the partner e.g., 'keeps promises', while other measures employ higher-level attributes such as 'dependability'. The third category of measures comprises those broad items that refer to trust (or trustworthiness) in a very general sense without reference to specific behaviours or attributes. The Likert-scale measure of generalised trust in another person or organisation belongs in this third category of trust measures. Most empirical studies now use items from both the behaviour and the attribute levels to assess trust. The majority of RM's trust research uses quantitative methods, measuring the trust experiences of customers according to conceptualisations and operationalisations of the phenomenon that are constructed from the previous literature by the researchers (e.g., Wong & Sohal, 2002, who draw on previous research done in 1988, 1990, and 1994).

Trust in the Health Care Context

Although there are plenty of passionate and prescriptive articles extolling the value of trust in patient-practitioner relationships, empirical research on the trust experience in a health care context is extremely limited. Moreover, the majority of this empirical research concerns trust in the patient-doctor relationship specifically, perhaps partly due to researchers' attempts to understand and explain the decline in trust in the medical profession. Also, biomedicine continues to be the dominant therapy in health care practice, research, and academic literature. Even though complementary therapies are rapidly becoming more mainstream, they are still seriously under-represented in the scholarly journals. Entering the phrase 'health care' into a computer search across the ABI Inform, Ebsco, and Emerald data bases resulted in very few

research articles focussed on complementary health care practice. However, research interest in the dynamics of relationships between patients and complementary health care practitioners is growing.

Patient Trust

While researchers seem to agree on the importance of trust to patient's health and health care, they define and conceptualise trust in a variety of ways. Some present patient trust as a set of beliefs about the practitioner's 'trustworthiness', those expectations held by the patient that the practitioner will behave in a certain way (e.g., Mechanic & Schlesinger, 1996; Thom, 2000). Competence, compassion, privacy and confidentiality, reliability and dependability, and communication are aspects of the practitioner's behaviour that are commonly linked to patient trust across the medical literature (Pearson & Raeke, 2000).

Other theorists, including those interested in complementary therapies but notably those from the nursing discipline who have worked diligently over the last few decades to 'legitimise' the caring side of health care, emphasise the affective dimension of the trust experience. This work, predominantly conceptual, stresses the patient's feelings of reassurance, confidence, and reliance in the practitioner (e.g., Chauhan & Long, 2000; Sundeen, Stuart, Rankin, & Cohen, 1994). It is in the sociology of health literature that we find discussions of the emotions that arise for patients around their experiences of risk, dependency, and vulnerability (e.g., Lupton, 1996, a qualitative study into the emotional features of medical encounters).

In the medical literature there is a general distinction made between two kinds of patient trust – general (or social) trust in the health care profession as a whole and interpersonal trust in an individual practitioner (Hall, Camacho, Dugan & Balkrishnan, 2002; Mechanic, 1996). These theorists contend that, typically, patient trust in an individual practitioner initially is based on general trust (in the profession) but evolves into interpersonal trust (in the practitioner) as the patient and practitioner get to know one another. The decline in the public's general trust in the profession and institutions of biomedicine, has obvious implications for this particular model of trust development. This theorising also supports the aim of this research, to understand participants' individual trust experiences in relation to their social and cultural contexts.

In a health care context trust is linked to patient satisfaction, adherence to treatment plans or recommended behaviour changes, and continuity with the practitioner, and improved health status (Derose, Hays, McCaffrey, & Baker, 2001; O'Malley & Forrest, 2002; Thom, 2000). Thom also details lower transaction costs that can be associated with patient trust: those costs involved in “reassuring the patient or reducing uncertainty, including additional tests and referrals, and costs associated with incomplete disclosure of information by the patient (2000, p. 246). For the patient, trust reduces anxiety and fosters empowerment as they take on more responsibilities for their health care (Johns, 1996; Leisen & Hyman, 2001).

Quantitative researchers attempting to measure trust within the patient-doctor relationship tend to favour one of the following three scale instruments:

- Trust in Physician Scale (Anderson & Dedrick, 1990). Eleven items that assess trust using the dimensions of dependability, confidence, and confidentiality of information.
- Primary Care Assessment Survey (Safran, Kosinski, Tarlov, Rogers, Taira, Lieberman, & Ware, 1998). Includes eight Likert-scaled questions using dimensions of integrity, agency, and competence.
- Patient Trust Scale (Kao, Green, Zaslavsky, Koplan, & Cleary, 1998). Ten items, focuses on the impact on patient trust of different forms (salary, capitation, fee-for-service) of physician payment.

In the midst of the quantitative research of patient trust in medical practitioners, the research by Thom and Campbell (1997) stands out – first, because it is qualitative, and second, because it is one of the few examples of research that actually grounds its conceptualisation of trust in the experience of patients. This research, which used four focus groups (20 women and nine men), distinguishes seven dimensions of trust in a physician, as experienced and perceived by the patients. These dimensions, which Thom and Campbell relate specifically to the physician-patient interaction, are: thoroughly evaluating problems, understanding the patient’s individual experience, expressing caring, providing appropriate and effective treatment, communicating clearly and completely, building partnership/sharing power, and demonstrating honesty and respect for the patient.

These trust dimensions all relate entirely to the practitioners’ behaviour; the research does not investigate the affective or behavioural aspects of patient trust, or the relational dimension (as discussed earlier in this chapter). Researchers Leisen and

Hyman (2001) have criticised the uni-dimensionality of the previous quantitative measures and the lack of quantitative validation of the 1997 Thom and Campbell framework and have developed a bi-dimensional scale (competence and benevolence) to measure patient trust comprising 51 items.

Some health care theorists working with the concept of trust argue that despite its common use in the contexts of health care, trust is an “immature” and “ambiguous” scientific concept that has been based largely on using previous literature as data (Hupcey, Penrod, Morse, & Mitcham, 2001, p. 282. Also Pearson & Raeke, 2000). Such observations underscore the need for researchers to collect new data for qualitative analysis of trust in patient-practitioner relationships in order to refine the concept of patient trust.

3. 3 Gender

Like trust, gender is a social phenomenon. Gender is socially produced (Annandale & Hunt, 2000; Lorber, 1997; Tavris, 1999). It is a process by which identities, roles, and behaviours are produced for, and by, those born male and female throughout their lives, and is embedded in the major social institutions and cultural practices of society. Whereas sex is biologically given, gender – “all those qualities, actions, and attributes we attach to one sex or the other” (Tavris, 1999, p. 6) - is a product of social conventions and located in our interactions with one another. We ‘do’ gender constantly – it is not a static or fixed demographic characteristic.

The process by which we become gendered human beings begins at birth, and by the time children are old enough to recognise that they are biologically female or male, they are also aware that there are ‘girl’ and ‘boy’ behaviours. Thus, we learn and live culturally defined personality traits that are linked to being female or male, and integrate them, as part of our gender identity, into our concept of self. These gendered personality traits are referred to in the literature as masculine traits and feminine traits; popularly stereotyped as instrumental/agentive for males, communal/expressive for females (Cross & Markus, 1993; Palan, 2001; Palmer & Bejou, 1995; Smith, 1998b).

Particular behaviours and activities, known as gender roles, are associated with the masculinity or femininity that we choose to adopt. Taken together these culturally derived gender norms, stereotypes, and values constitute a central part of our socialisation and self-identity, providing a filter through which we sort our experiences and perceptions of ourselves and the others in our lifeworld (Palan, 2001; Spence, 1985).

But our gender behaviour is not just shaped by social institutions (e.g., education, the family, the legal and medical systems, religion), social forces (e.g., political and economic ideologies), and the dominant cultural norms and mores. Gender also depends as much on the behaviour of that person with whom we are interacting at any given time – our partner, our friend, our lecturer, our doctor – and their gendered expectations of us and responses to our interactions within the relationship. There is always a social context to gender. Gender, as a phenomenon, is co-constructed in relationship with others.

Finally, the individual can have some degree of choice with regard to the way in which s/he ‘does’ gender, and thus can also bring agency to the construction of gender. Therefore, gender is being continually constructed by the individual, in negotiation with the other person(s) and the social structures lived out within any one relationship. In this way then, the individual both creates and acquiesces in gender as a social construction (Annandale & Hunt, 2000; Haug & Others, 1987; Lorber, 1997; Popay & Groves, 2000).

Conventional wisdom and research on gender, emphasising the male or female occupancy of distinct social roles, and gender as difference, has given way under the accelerated rate of social change over the past three decades, to new conceptualisations of gender. Contemporary knowledge on gender is focussed on the interactional dynamics, evidenced in the move away from male-only and female-only samples to gender comparative samples; and a much wider attention to the complexity of interacting roles and statuses, and people’s gendered experience of roles as they are actively constructed in real lives. This new framework accounts for the movement of men and women between what were once regarded as either male or female dominated social roles, and challenges researchers working with gender to use methodologies and theories that are sensitive to the new “gender order” (Annandale & Hunt, 2000, p. 24).

So, rather than a simplistic male/female binary, these more intricate, non-linear patterns of gender acknowledge differences within men and within women, and allow for new areas of commonality between men and women (Annandale & Hunt, 2000; Coltrane, 1994; Graham, 1993; Macintyre, Hunt, & Sweeting, 1996). Within this new

framework, work on social roles has broadened considerably, to explore the actual experience of roles and the meanings that they carry for men and for women, the various elements of gender roles (e.g., behaviours, congruency and conflict, attitudes and beliefs), and the interaction of these with lived experience (Hearn & Collinson, 1994; Helgeson, 1995; Sabo & Gordon, 1995).

While this framework certainly accounts for the complexity and fluidity of the gender order as we live it today, some theorists advise caution in applying it. Annandale and Hunt argue, for instance, that the more fluid movement in and out of what were traditionally either male or female roles, and concomitant changes in statuses, should not be viewed simplistically as the “diminution of patriarchal privilege, but rather its continuation in new forms” (2000, p. 21). Popay and Groves (2000), likewise, urge gender researchers to be alert for new patterns of oppression and disadvantage, as pointers to such changes in the social relationships of power and control within the contemporary gender order.

In plain speak, we are called to be concerned theoretically with similarities between men and women, with diversity among men and among women, and with dimensions of postmodern patriarchy that can affect men as well as women. Other important issues around current gender conceptualisations concern its measurement, and competing theoretical foundations (gender schema theory vs. multi-factorial gender identity theory).

Gender in Marketing

Most of the research done on gender within the discipline of marketing is found in the consumer behaviour literature. The majority of these studies were conducted and published when gender was widely theorised as a dualistic concept; that is, masculinity and femininity were modelled as binary opposites on the one continuum. While these studies might not be experientially relevant for the contemporary man or woman, or theoretically sound for today's gender researcher, nonetheless they do help to chart the scope of gender research to date and provide some degree of conceptual sensitivity for this study.

Because there is so little research on gender and trust, and more particularly, gender and trust in the context of health care services, I will survey the literature that does exist on these topics in more detail than the literature on trust. The aim of the final section of this chapter thus becomes more focussed on ascertaining the scope of relevant literature around gender and trust to ensure that this research extends extant knowledge.

Researchers have detailed the impact of gender on a diverse range of buying and consuming behaviours, such as gift-giving (Palan, Areni, & Kiecker, 2001), sports sponsorship (Kinney & McDaniel, 2002), information processing styles (Meyers-Levy & Durairaj, 1991), the perception of retail environments (Nuttavuthisit & DeBerry-Spence, 2002), consumption emotions (Dube & Morgan, 1996) advertising preferences (Jaffe, 1991), and addictive shopping (Woodruffe-Burton, Eccles, & Elliott, 2002). As is to be expected, this body of research concentrates on quite

specific aspects of the consumption behaviour of female and male customers, and how those aspects are related to purchase processes and outcomes.

Studies from services marketing and relationship marketing provide some insights to how gender impacts on the broader relational aspects of exchange relationships. A handful of work from the last decade suggests that men and women differ in their approaches, management styles, and the values they use in marketplace relationships. Ostrom and Iacobucci (1993) find that men and women are likely to evaluate services differently, according to the perceived competence of the provider, the perceived interpersonal abilities of the provider, and the service provider's gender. This research finds that women may be more sensitive to relational aspects of a service relationship and men to core aspects. Further research suggests that females are more likely than males to become emotionally attached to a service provider (Shemwell Jr., Cronin Jr., & Bullard, 1994).

Work by Palmer and Bejou (1995), Smith and Bejou (1995), and Smith (1998b) finds that women tend to have greater relationship management skills than men, and manage their buyer-seller relationships differently than men. Smith's research suggests that women and men can use quite different relational bonds (social, functional, or structural) in their relationships, and also found between-gender differences in reported relationship quality.

These findings are consistent with other empirical studies that report differences between men and women in their relational orientation (e.g., Riger & Gilligan, 1980), expectations (Sherrod, 1989), communication styles (Tavris, 1992), network

development (Ibarra, 1992), and ethical orientation (Betz, O'Connell, & Shepard, 1989). However, empirical research into gender effects has not been unequivocal, and all of the above researchers take a cautious approach to both reporting and interpreting their findings. This caution from the field serves as yet another reminder of the complex nature of gender. However, taken together, studies such as those detailed above support the need for research such as this that explores the interplay between gender and relational phenomenon such as trust, and can lead to important implications for marketing theorists and service providers alike.

Gender and Trust in Customer-Provider Relationships

There is very little empirical research specifically on the interaction of gender and trust within a customer-provider relationship. The most recent marketing research into the connection between gender and trust, conducted in an e-commerce context, reports marginal, statistically insignificant gender differences in online trust relationships between customers and e-tailers, and suggests that earlier reported gender differences towards online shopping are diminishing (Kolsaker & Payne, 2002). This is in line with leading gender theorists who propose that gender effects are changing with the blurring of traditional gender roles (e.g., Annandale & Hunt, 2000; Blattel-Mink & Kuhlmann, 2003; Popay & Groves, 2000).

Palmer and Bejou (1995) investigate the effects of gender on service relationships, this time between clients and financial advisers. They find significant links between gender and aspects of the relational interaction, specifically the impact of gender on the customer's perceptions of the provider's empathy and selling orientation (treated as aspects of relationship quality). They report that women perceived greater empathy

in their relationships with financial advisers (compared to male customers), and men perceived more pressure to buy (than the women customers). However, Palmer and Bejou dismiss as too simplistic the use of stereotypical gender-based personality traits to explain the results. Instead, they explore both the application of gender role expectations at work in the customer-provider relationship, and gender schema theory in an attempt to gain a fuller interpretation of the survey data.

An earlier empirical study of gender and ongoing customer-provider relationships also posits direct links between gender and trust. Shemwell Jr., Cronin Jr., and Bullard (1994), examining the importance that women and men give trust and commitment in their primary care physicians, car mechanics, and hairdressers, find that, overall, the women showed greater trust than the men in their relationships with all three service providers. The results also indicate that the women were more likely than the men to establish an emotional bond leading to commitment to an individual service provider, and to seek out and continue service relationships with providers whom they trust. The researchers contend that these results support previous findings in the psychology and sociology research that women are more likely than men to be relationship oriented, explaining these gender patterns by reference to stereotypical feminine and masculine traits concerned with collectivity and agency respectively.

A second group of literature actually discusses both gender and trust but does not make an explicit connection between them. Martin and Adams (1999), for example, in research that measures selected interpersonal behaviours in service contexts, such as establishing eye contact and smiling, finds frontline staff alter their service behaviour according to customers' demographics. The men were less likely to get conversation,

smiles, eye contact, or verbal appreciation from behind the counter. Service providers tended to show service favouritism towards the women, and the women customers tended to rate service quality higher than the men. The interpersonal behaviours chosen for study here are conceptualised as contributors to perceived service quality, and trust is acknowledged as a dimension of relational quality within that. However, the links between interpersonal behaviours biased toward gender and the customers' experience of trust within the service relationship are neither investigated empirically nor made explicit theoretically.

Finally, a third group of research, in studies of consumer behaviour other than trust, establishes links between gender and aspects of the customer-provider relationship that trust theorists regard as integral to trust in a service context. For example, Stafford (1996) finds that the service provider's honesty and reliability are more important to women than men (albeit very important across both genders) in terms of bank service. Research like this, while not addressing gender-trust connections directly, can be used to enrich our understanding of their interaction.

So, despite the fact that the concepts 'trust' and 'gender' do appear together in a number of articles, and have been both treated as variables in the same empirical studies, there is very little research that sets out to investigate the dynamics between the two. Given the acknowledged importance of both gender and trust in the construction of our relationships, in all sectors of our lives, I believe that this research will provide a sound starting point for deepening our understanding of their interconnection.

3. 4 Trust And Gender In The Health Care Context

Separately, the two concepts of trust and gender have respected positions in the contemporary health care context. Trust is regarded as critical for healing and a key dimension of successful patient-practitioner relationships. In summary, trust increases the individual's willingness to seek care from a health care practitioner, disclose personal information, undergo treatment, and follow the practitioner's advice (e.g., Johns, 1996). From a marketing perspective, trust fosters patient retention and positive word of mouth which increases earnings (e.g., Leisen & Hyman, 2001). Trust issues also are key in the wider negotiations on the structure of health care systems, and debates on its delivery (e.g., Hall, Camacho, Dugan, & Balkrishnan, 2002).

Gender is understood to exert a major impact on patients' experience of health and health care because of its power as a social force in this context (as explained in Chapter 2). Initially, the work on gender in health care focussed on gender inequalities (where 'gender' typically is superimposed onto biological sex) in mortality and morbidity rates that are characteristic of Western health care systems. Historically, women have been the focus of this health inequalities research. Since the 1990s however, a research stream has become evident in the literature that is concerned with men's health and men's disadvantages in health (e.g., Cameron and Bernades' 1998 research into men's experience of prostate ill-health).

Recently, too, researchers have begun to examine more deeply the impact of gender, in the wider sense of the concept, on our health care experiences. Gender is now considered one of the most significant factors in the social construction of health and illness: it "creates different risks and protections for physical illness, produces

different behavior when ill, elicits different responses in health care personnel, affects the social worth of patients, and influences priorities of treatment, research, and financing” (Lorber, 1997, p. 2). Gender impacts on illness through our economic circumstances, our work and family responsibilities, lifestyle choices such as diet and exercise patterns, and our patterns of interaction with the health care practitioners with whom we work (Annandale, 1998; Lorber, 1997; Popay & Groves, 2000).

Gender effects that have been noted in various health care contexts indicate that men tend to be less concerned about a variety of health risks than women (Andaleeb & Basu, 1995; Kahn et al., 1997); women are more likely to seek medical treatment for a given set of symptoms than are men (Kahn et al., 1997); men tend to keep quiet about their health problems, even with partners or close families (Cameron & Bernardes, 1998), and women report higher overall satisfaction (with their physicians) than male patients (Mummalaneni & Gopalakrishna, 1995).

Interpretations of findings such as these that involve between-gender comparisons and reveal important gender differences often turn on contemporary theorising around patients’ lived experience of masculinities and femininities, negotiated gender roles, and issues of agency and structure. Between-gender trends in experiences of health care can reflect both the persistence of traditional gender stereotypes for patient behaviours and beliefs, and the degree of change as women and men practise new ways of being a patient. Many of these new ways cross gender boundaries that not so long ago were clearly defined and understood by patients, practitioners - and academic researchers. Contemporary gender is complex. Lived in a complex service

setting such as health care it can become even more complicated, and all the more intriguing.

Again, most of the research that does check the connection between trust and gender in a health care context, superimposes ‘gender’ onto biological ‘sex’ and then treats the concept as a demographic in isolation from the health care context. Typically then, these studies do not explore the extent to which gender shapes the experience of patient trust and, not surprisingly, report little significant interconnection between gender and trust (e.g., Hall et al., 2002; Thom, Ribisl, Stewart, Luke, & The Stanford Trust Physicians, 1999). Moreover, these empirical studies tend to employ quantitative methods, often using items the researchers have adopted and/or adapted from previous literature to test their hypotheses.

Given the salience for patients of both trust and gender, and their potentially profound effects (as separate influences) on patients’ experience of health care, it is reasonable to expect that together they could create an important dynamic in patient-practitioner relationships. To date, research that explores specifically the interaction of trust and gender in any health care context is extremely scarce. Therefore, this research, which investigates the connection between gender and the experience of trust between patients and their primary health care practitioners, seeks to provide insight to the lived interaction of trust and gender from the patients’ perspective and across a range of primary health care contexts. This research also answers various calls by scholars of trust and of gender for qualitative research in both these areas (as detailed earlier), especially qualitative research that allows the patients to define and describe their

experiences of these crucial social phenomena, and to establish as a collective, the theoretical framework for a deeper understanding of their data.

3. 5 Concluding Comments

Trust is a complex, dynamic social phenomenon that is context-specific, as detailed in this and the previous chapter. At the conclusion of this overview of the trust literature it is clear that, rather than assess a ‘trust’ that has been defined and modelled for them by the researcher, more qualitative research is needed that allows the participants themselves to define and describe trust as they experience it in certain contexts. Such research would help trust scholars to recognise those dimensions of the phenomenon that are dominant in particular circumstances and those dimensions that are common across situations. In addition, it is apparent from this survey of the gender literature that research investigating gender must allow for the heterogeneity and plurality of experience which characterise the ways we live gender today. Accordingly, this research sets out to enable men and women to identify the salient, most meaningful dimensions of trust from their perspective as patients, and to articulate the theorising by which they make sense of their experiences.

While this chapter is traditionally the ‘right’ place in which to present a theoretical framework for the research, it would both inappropriate and counter-productive for me to do so. A pre-set framework implies that the participants’ data can be moulded on to fit. This latter, more ‘traditional’ approach promises a tidy package at the end of the research process, but it also risks missing new insights hidden in those bits of data that just don’t fit. Certainly, I began the research assuming that I would conduct the research and structure the thesis using traditional academic protocols of process and

order. But it has become apparent that in order to communicate the participants' lived experiences of trust the research and thesis itself have to reflect the "perceptions of meanings, definitions or interpretations that respondents provide" (Carson, Gilmore, Perry, & Gronhaug, 2001, p. 152). This approach is in line with some of the basic principles of grounded theory, notably the emphasis on flexibility in the research process to allow the researcher to follow frameworks that 'emerge' from the participants' data (see Carson et al., 2001 for a full discussion of grounded theory and methods).

However, the topic of this research suggests that theory that helps us to understand genderisation and gender role theory, socialisation (including customer socialisation), roles and scripts in service encounters, and relationality might be relevant. Exactly which theories will be used will be determined by the participants. A theoretical framework to extend the analysis and theorising done by the participants will be developed later in the research process and presented in Chapter 8. This framework, based on the concepts and theories used by the participants to make sense of their trust experiences, will facilitate the connections between their work and existing knowledge.

3.6 In My Own Words

This chapter has been an iterative process at several different levels. It morphed through various drafts as I wrestled conceptually and logistically with the vast literature around trust and gender, and then plunged into the nursing literature when I couldn't find work in either that reflected what the participants expressed. The final draft is structured on the participants' own system of making sense of their trust

experiences. Once I had recognised the relevance of the participants' meaning-making framework to this jaw-droppingly huge pool of academic knowledge the job was easy. The result has been a final excitement and confidence that I/we at last have found a way of organising the literature so that it can inform and support the participants' work. But more than that, on the way through I have clearly recognised the major theoretical links that will provide the connection points for extending our knowledge on trust and gender.

4: Methodological Considerations

“If our need is for meaning, then we need a science of the spirit...” (Zyzanski, McWhinney, Blake, Crabtree, & Miller, 1992, p. 242).

4.1 In My Own Words

This chapter has been an exciting one for me, and exists as evidence of huge growth for me as a person and as a researcher. It has challenged me to name my turangawaewae (this Maori word conveys perfectly the richness of a person’s sacred home ground – a place redolent with history, family, and community). In order to declare my position, to honour my starting point, that place where my roots are planted, I had to go off and find out where it was. I searched alone and without success for a time, then a mentor had me write her a passion statement to explain what was firing the research.

In this we found some of the features of my turangawaewae. At that stage I went away and tried to label my position according to the coordinates of ontology, epistemology, and methodology. To begin with I tried whole paradigms for fit, and when that didn’t work I tried deconstructing my passion and force-fitting fragments of it to the most likely-looking philosophical maps. For a time, I followed the advice of theorists who advocated building bridges over the gaps; only to discover that while it sounded fine on paper, I didn’t know how to engineer a structure that was stable enough to support my passage from one region to another. Finally, more than a year after I had

articulated my passion, I re-read Lincoln and Denzin (2000) and now know with all surety that I have found my place.

In this chapter I describe the contours of my turangawaewae - with great pleasure - using the preferred language, conceits, and protocols of traditional academe.

4.2 Introduction

To be fully understood and properly evaluated, this research on trust as a consumer behaviour must begin with a full discussion of the underlying assumptions of human behaviour that I hold, in my academic role as ‘researcher’ (Bateson, 1972; Denzin & Lincoln, 1998; Janesick, 2000; Marsden & Littler, 1998, Schwandt, 2000). Therefore, the following sections will detail the philosophical structure that has shaped my entire research process, from the type of questions that initially engaged my curiosity, to my choice of methodology, and the interpretation and evaluation of the data.

Firstly, I present the theoretical picture that this research fits into, to demonstrate that the same philosophical assumptions that underlie my declared ontology, inform my theoretical orientation, and support my research methodology. Then I outline the epistemological basis of this research; and finally, detail Memory Work, the method I have chosen to conduct this inquiry into how men and women experience trust in a primary health care practitioner (PHCP). The focus of this chapter then is squarely on the philosophical and methodological considerations relevant to this research. The following chapter, Chapter 5, has a more practical focus; in it I detail the actual research processes used to implement Memory Work. Therefore, the description of Memory Work ranges across two chapters that present the philosophy and theory of

Memory Work as a base, and then the specific application of Memory Work in the context of this research.

4.3 Ontology

My view of the consumer as a human being allows for change, ambiguity, and journeying, as we interact with our environment, interpreting, understanding, and continually ascribing meaning to our individual life-worlds. At the same time, our social worlds, to varying degrees, are shaping and reshaping us through the contingent normative guidelines within which we are being ‘creative’.

We give our actions meaning relative both to events and to the people with whom we share our lives. Thus, there are as many constructed realities as there are human beings, although elements are often shared among individuals and across cultures (see also Reinharz, 1992; Schwandt, 1994). So, reality is socially and experientially based, and is both local and specific in nature. In describing my worldview thus, I am declaring a relativist ontology, as opposed to an objective, scientific framework. The assumption at the centre of my ontology is that an individual’s life is a socially constructed whole, in which we work as individuals to interrelate our experiences for coherency and meaning (see also Goulding, 1999, Hudson & Ozanne, 1988), as we ourselves are being formed by social forces (such as gender) in the process (see also von Cranach, 1995).

Thus, I reject the determinist idea that a human being is a reactive entity that behaves in response-reinforcement style to the external world. Likewise, I renounce the cognitivist view that we are disengaged, rational, information processors whose

behaviour is determined by internal subjective states (see also Hudson, 1988). These perspectives would have us existing in a world that is a “foundational, mind-independent, and permanently fixed reality” (Schwandt, 2000, p. 201). Reality there is external, measurable, and controllable. Therefore, in this positivist world, trust would be extracted, experimentally measured, and analysed rationally as a single objective truth, part of the concrete unchanging whole.

Instead, I believe that we each create our own realities; however, we construct our realities as individuals within relationships (McNamee & Gergen, 1999). Each of us uses particular theories and categories to make sense of the world as we experience it, and we ‘test’ this knowledge for fit against our own past experience and those worldviews communicated by the organisations and people who are socially significant to us. Then we reshape that reality again (see also Gergen, 2001; Schwandt, 2000; Shotter, 1993).

There are multiple realities because there are multiple perspectives; these realities are dynamic, complex, and multi-faceted. They are contextual because as social beings we develop meaning based on context, and bound also by time. Thus, the trust I experienced in my GP yesterday is different from the trust I had for the car salesman I bought my car from last year. Our realities are holistic in that they are the sum of the interdependent meaning-making systems we employ in our daily lives. For example, my trust in a GP is dependent on a range of systems for its meaning - my culture, my gender, my age, my attitudes and values, my religion, my education.

4.4 Epistemology

My worldview is grounded in a sense of the sacred inherent in each of us, as well as the sacredness that unites us with other humans and with the environment. This acknowledgement of the sacred dimension to life is a crucial characteristic of my personal philosophy that proved troublesome when I was trying to fit myself to one or other of the interpretive paradigm-profiles. But it is this characteristic that enables me now to identify wholeheartedly with qualitative researchers who use an existential, interpretive model of inquiry that is centred on a “sacred epistemology” (Lincoln & Denzin, 2000, p. 1052).

This sacred epistemology positions us in a cooperative, nonhierarchical relationship to others, to nature, and to the larger world. It emphasizes the sacredness of life, human dignity, truth telling, and non-violence (see Christians, 2000; Reason, 1993). It is based on a philosophy that declares: “All humans are worthy of dignity and sacred status without exception for class or ethnicity” (Christians, 1995, p. 129). It challenges us to examine the ways in which race, class, and gender can act as oppressive forces in our lives today. Such investigation into the power plays enacted in our daily lives therefore provides this epistemology with political teeth; in this way it can be regarded as setting a critical and moral tone to inquiry agendas.

This epistemology insists that as researchers we make ourselves visible in our texts, each of us as an individual worthy of equal respect, and absolutely capable of representing the self in its working relation to the world. No one individual is privileged in the inquiry process. The researcher and participants work collectively and equally to co-create the ‘findings’ in interaction, as the research proceeds. The

epistemology favours narrative accounts in which we can each tell our stories about how we enact and construct meaning in our daily lives (Lincoln & Denzin, 2000).

As described by Lincoln and Denzin (2000), this epistemology is developing as part of a growing philosophical movement opposed to the prevailing ideologies of materialism and individualism that have produced a race of human beings brought up on the science of satisfaction and enculturated to a highly competitive lifestyle. This way of life offers plenty of support for self-gratification but little in the way of meaningful satisfaction and self-fulfillment. The long-term dehumanising and disempowering effects of these ideologies have engendered the ideal conditions for commodification, under which people are corralled into homogeneous target markets in the interests of business efficiency and profit maximisation.

The key principles of marketing reflected and indeed encouraged such commodification for several decades, until relationship marketing persuaded us to recognise and relate to customers as individuals. But while relationship marketing acknowledges the importance of meaningful relationships with each customer, prior research has focussed primarily on the benefits of long-term customer relationships from the point of view of the provider, and developing these relationships in order to increase profits (e.g., Berry, 1995; Reichheld & Sasser, 1990; Reichheld & Schefter, 2000; Sheth & Parvatiyar, 1995). From this perspective, better relationships are the way to better profits and customers become, by implication, simply the means to that end. Typically they are neglected as culturally and historically situated human beings who bring into the marketplace a complex package of personal factors that shape their consumption decisions. It is only now as marketing research moves to understand how

the social-cultural contexts of individuals interrelate with their behaviour as customers, that we begin to come closer to a much deeper understanding of market relationships and phenomena (Friend & Thompson, 2000).

While this emerging sacred epistemology constitutes the major foundation of my personal epistemology, I also use building blocks from other interpretive paradigms (e.g., social constructionism and feminism). Social constructionism, for example, has an important place in my philosophy. Constructionism, based on the belief that “human beings do not find or discover knowledge so much as we construct or make it” (Schwandt, 2000, p. 197), enables us to conceptualise knowledge as a ‘co-construction’. Because we construct our knowledge in relation with other people, it has distinctive historical and social-cultural dimensions that must be taken into account if we are to understand and respect other (multiple) realities. The social constructionism paradigm also supports a transactional/subjectivist epistemology that emphasises research findings which are created interactively and focussed on shared meaning, rather than on individual minds and cognitive processes (Dachler & Hosking, 1995; Denzin, 1994; Guba & Lincoln, 1994; Schwandt, 2000).

From this epistemological standpoint then, I was committed to studying trust from the perspective of the participants as interacting individuals. I worked with them as gendered, historically and culturally situated individuals who were the experts in co-constructing and enacting the meaning of patient trust. I sought an understanding of trust through their experiences of it as a phenomenon firmly embedded in their social worlds.

In this research I was seeking answers to questions that focused on how trust was experienced as a relational, socially embedded phenomenon, and how female and male patients gave meaning to the trust they extended to their primary health care practitioners. My goal was to understand trust as it is experienced by patients – not to predict it, nor determine the causal effects around it. More specifically, I was aiming to achieve a comprehensive understanding that explored the *verstehen* (the concept of the shared meaning within a culture of language, contexts, roles, gestures – see Patton, 2002; Schwandt, 2000) of patient trust and its interaction with gender, but which also respected individual meanings within that.

4.5 Methodology

Qualitative Research

This research used qualitative methodology. Contemporary qualitative research has evolved into a diverse field of inquiry that Lincoln and Denzin (2000) describe as “an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field...[that] is multi-paradigmatic in focus...inherently political and shaped by multiple ethical and political allegiances” (p. 1048). It is multi-method in focus, meaning that qualitative research typically involves using a range of complementary empirical methods and practices with the hope always of getting a better fix on moments and meanings as they are lived by participants.

The overarching aim of qualitative research appears to be constant though: To gain a thorough, in-depth understanding of particular phenomena in particular contexts (see Cresswell, 1998; Denzin & Lincoln, 1998, 2000; Grbich, 1999). Qualitative

researchers share a commitment to “the naturalistic perspective and to the interpretive understanding of human experience” (Lincoln & Denzin, 2000, p. 1048). Thus, qualitative researchers study phenomena in their natural settings, working to interpret those phenomena in terms of the meanings individuals give them in the course of their everyday lives.

The Qualitative Researcher

The contemporary qualitative researcher, rather elegantly portrayed by the theorists Lincoln and Denzin as the interpretive *bricoleur* (originally the phrase of Levi-Strauss) creating quilts of understanding, is working in a time characterised by uncertainty, change, questioning, and great potential that marks the beginning of the “seventh moment” (Lincoln & Denzin, 2000, p. 1047) of qualitative research. The *bricoleur* employs a wide range of research ‘tools’, chosen depending on the questions being asked and the nature of the context. This researcher also moves between perspectives and paradigms, always working to produce an in-depth understanding of the phenomenon in question.

I came to this research equipped with certain skills that enabled me to use narrative, interview, and group techniques as interpretive research practices, but I was also happy to learn new skills or invent new tools as the research proceeded. I am comfortable moving between different perspectives for insights that will enrich our understanding – this “pluralism” is supported in the marketing discipline by interpretive theorists such as Foxall, who holds that the growth of knowledge depends on “paradigmatic erosion and synthesis” (2000, p. 770). At the end of this particular research process, I trust that we will have a *bricolage*, a rich, complex, thick quilt

creation that represents the reflections, understandings, and interpretations of the phenomenon of trust for the male and female patients of this research.

Justification of the Qualitative Approach

A qualitative approach was the appropriate choice for this research, given

1. that the research aim was to explore unknown aspects of trust from the patients' perspective; and
2. the interpretive nature of my personal ontology and epistemology.

The traditional quantitative research paradigm was inappropriate for this research.

Quantitative inquiry is framed on the ontological belief that reality is 'out there' and able to be ascertained in the form of testable facts. It emphasises definitions, precise objective measurement, the manipulation of variables, and analyses aimed at producing a generalisable and universal 'truth' (Silverman, 1993; Zyzanski, McWhinney, Blake, Crabtree & Miller, 1992). Undoubtedly, quantitative research methodology has provided us with much valuable knowledge. However, in this research it would have been ineffectual for revealing the complexities involved in the experience of trust of a male or female patient in a particular health care practitioner for a particular problem at a particular time. On the other hand, qualitative methodology offered me the opportunity to design a study that could explore patient trust as a multi-faceted phenomenon, relative to context and the meaning of events and experiences constructed by the participants themselves.

Generalisability

I did not intend to produce a grand generalisation from this research - in the psychometric sense of 'generalisation' as a methodological concern from the quantitative paradigm. The purpose of this research, as of all qualitative research, was explanation and understanding, not prediction. Quantitative 'generalisation' requires abstraction and I was deliberately forgoing abstraction in the interests of enriching our knowledge of patient trust. Abstraction leaves out the situational and historical contexts and I chose deliberately to take those contexts into account.

Qualitative research enriches our knowledge of particulars rather than giving us the large lawlike generalisations we associate with deductive positivist methods. As a qualitative researcher, I intended to examine the participants' experiences for common, shared aspects of trust. By uncovering such traces of the universal in the individual experiences of trust I would be generalising in the qualitative sense of the word (Dachler & Hosking, 1995; Denzin, 1983; Williams, 1998). Such qualitative 'generalisation' rests on the intensive analysis and interpretation of a small number of cases, arguing, after Sartre (as cited in Denzin & Lincoln, 1994, p. 202), that each individual is a single instance of more universal social experiences and processes. The search for similarities across the individual experiences in this research aimed to construct patterns of commonality rather than an ultimate 'truth' about trust and/or gender.

Validity and Reliability

Likewise, I was not overly concerned with validity and reliability, the other two members of the quantitative design ‘trinity’ (Janesick, 2000, p. 390). While these three constructs are regarded as the standard methodological checks for establishing the credibility of quantitative methods, in their traditional form they are incongruent with contemporary philosophies of qualitative research and inappropriate in this context.

For some time now, qualitative researchers have been working to reconceptualise and replace such psychometric devices with tools that will ensure the credibility of qualitative research (see Flick, 1998; Lincoln & Guba, 1985; Janesick, 2000; Wolcott, 1995). I was not choosing to abandon ‘rigour’ during this research process, but was not happy with the connotations of the traditional positivist research terminology and techniques. So, with the support of these researchers, I set out to employ both the new language of qualitative research design and certain re-conceptualised terms from the vocabulary of the quantitative tradition. I focused my efforts on the quality criteria of trustworthiness and authenticity (following Guba & Lincoln, 1994), rather than looking to the quantitative trinity for guidance. I will discuss briefly these criteria in the following section, and throughout the document detail my efforts to address quality issues as the research proceeded.

Trustworthiness

‘Trustworthiness’ is concerned with the research’s accuracy, credibility, and believability. There are a number of strategies available to enhance these qualities, including maintaining an accurate and detailed record of the research process (Crabtree & Miller, 1992), verification by research participants (Kincheloe & McLaren, 1994), triangulation (Grbich, 1999; Janesick, 2000), and reflexivity (Marcus, 1994). This research employed all these strategies, and I detail them when appropriate throughout the text. By using these strategies I was attempting to ensure that the research was both consistent (internally and externally) and coherent. The final test of trustworthiness of this research lies in the reader being convinced that I have accessed and accurately represented the phenomenon of patient trust for these men and women, and that I have presented a complete and carefully checked investigation of their experiences.

Authenticity

‘Authenticity’ refers to a range of criteria that distinguish rigorous qualitative research: fairness, ontological authenticity, catalytic authenticity, educative authenticity, and tactical authenticity (Lincoln & Guba, 2000). These criteria are concerned with researching to ensure that all stories are represented with integrity, and that the research effects some level of change in the awareness or behaviour of those people who are connected with the project (either directly or indirectly). The debate on these and other various points of qualitative research design looks set to continue for some time (see Janesick, 2000; Lincoln & Denzin, 2000; Lincoln & Guba, 2000). Because of their fit with the paradigms and purposes of this research I

chose to use the notions and criteria discussed above to develop the quality of this research.

In summary, traditional quantitative methods cannot capture the complexity of the individual's experience of trust. Therefore, this research employed a qualitative method that enabled trust to be explored as a dynamic, multi-faceted phenomenon constructed by the individual in interaction with others - specifically, the health care practitioner as trustee in the health care context, and more indirectly, those other people who had influenced the individual patient's experiential knowledge of trust over time. The choice to use a qualitative method also allowed for investigating the interaction of gender with the participants' lived experiences of trust.

4.6 Memory Work

The ultimate goal of this research was to uncover and understand the patients' experiences, feelings, and beliefs about their trust in primary health care practitioners. I was seeking to explore the patients' meanings and interpretations of trust, from their perspective rather than to presume that as a researcher I already knew what the appropriate questions and answers were. I also wanted to understand the relationship between gender and the experience of trust for these patients. It was crucial to me that the male and female patients framed as much as possible of the knowledge and understanding of trust that this research generated. These aims and concerns were particularly well suited to the method of Memory Work.

Memory Work, a collective and deconstructive method of inquiry, offered a means to explore the fullness of the trust experience. It recognised the expertise and rights of

ordinary human beings ‘doing’ life and valued them as creators and repositories of knowledge. The method is grounded in narratives written by the ‘experts’ (Denzin & Lincoln, 1998) in the field – in this case, the women and men who lived trust in their relationship with their PHCPs. These individual narratives are examined by the collective, using the frames of reference the ‘experts’ choose as the most appropriate for understanding and expressing the phenomenon being studied.

Development of Memory Work

This social research method was developed by Frigga Haug (1987) and her colleagues, a group of feminist researchers and scholars who found themselves increasingly dissatisfied with the dominant cultural ideologies and research canons that did not see or hear women’s realities. They developed the method specifically to explore women’s gender socialisation and its relation to the process of sexualisation of the female body. Their focus was on the processes whereby individual women become women in the social sense, but also on the way in which the female body is constructed as a socio-biological unit.

Their research question centred on the ‘how’ of lived feminine practice: “Our aim was to identify the ways we live ourselves in bodily terms, the ways we live in our bodies, and in so doing to define and determine our relation to other human beings and to the world” (op. cit., p. 30).

Our collective empirical work set itself the high-flown task of identifying the ways in which individuals construct themselves into existing structures, and are thereby themselves formed; the way in which they reconstruct social structures (op cit., p. 41).

Their broader political goals were to disentangle the female body from its “constricted framework of sexual meanings” (op cit., p. 13); to construct a discourse and a methodology in which the female body exists as a social entity; and thereby, to offer individuals the chance to intervene consciously in the prevalent social relations structuring their worlds.

The goals of the Haug group and the methodology that developed out of those overarching aims, underscore the appropriateness of Memory Work for this research project with its focus on understanding how the participants’ individual experiences of trust have been constructed by the self, and the social processes of gender on self.

Theoretical Framework of Memory Work

Memory Work was built on a framework of Marxist and feminist theories. The original group of researchers addressed issues around the division of labour, power, and social subjugation in the method’s emphases on the collapse of subject and object, collectivity, reflexivity, and personal emancipation through awareness (with its potential for individual and/or political change). The method also has strong roots in critical and social constructionist views of the world (Ingleton, 2000).

The major theoretical assumption made by the Haug collective is that the social relations into which individuals are born are always pre-patterned in given ways (rather than the result of individual choice). So, as human beings we live within social relations that present structural barriers to our individual quests for autonomy and self-determination. Underpinning this is a second assumption – that individuals are not passive victims but active social agents who acquiesce in social structures and

relations that they themselves do not consciously determine, and thus unconsciously participate in forming.

One of the chief epistemological features of Memory Work is its insistence that the subject and object of knowledge are inseparable. Indeed, Haug declares that “memory-work is only possible if the subject and object of research are one and the same person” (1987, p.35). This perspective recognises us as the “experts in everyday life” (ibid.) and legitimises our own daily experience as a basis for ‘scientific’ knowledge. Memory Work uses experience as its empirical base, formalising and theorising experience to explore how our lives are shaped by our experiences; more particularly, the meaning that we, in relationship with our self, others, and the wider social structures of our lives, ascribe to our experiences (Haug & Others, 1987, 1992; Ingleton, 2000; White, 1995). This recognition of the legitimacy of experience is a central tenet of social constructionism, reflected in the relativism of its ontology and the transactional nature of its epistemology (Guba & Lincoln, 1994; Schwandt, 1994).

In claiming experience as a legitimate basis of knowledge, Memory Work challenges the separated, abstracted knowledge of mainstream quantifying research, built on the positivist premise that individuals’ accounts of themselves are too coloured by subjectivity to be trusted. Memory Work explicitly engages with subjectivity. Group members write their personal stories with as much detail as possible, then share and interpret these memories as a group, peeling away layers of meaning to uncover “the relationships between experience and subjectivity, experience and knowledge” (Stephenson, Kippax, & Crawford, 1996, p. 183).

Memory Work's Collectivity

In Memory Work the group is regarded as a collective of co-researchers who are their own subjects, engaged in the interpretation of both self and others, and who have equal status in the research process (Friend, 2000). So, in accordance with Haug's research philosophy and design, the academic researcher is required to become an active member of the group. The academic researcher becomes one of the co-researchers. And the researchers become the researched. The power differential between researcher and subject is dismantled, and the collapse of that hierarchy challenges the assumption that the academic researcher has some privileged access or right to knowledge that is denied to the research subject. With this deliberate reconnecting of knowledge and everyday experience, Haug presents Memory Work as a means to bridge the gap between theory and experience – a gap that is a source of great concern to me personally and to other contemporary feminist and social constructionist researchers (see Gergen, 1994; Ingleton, 2000; Johnston, 2001; Small, 2000).

Intimately connected with the collapse of the object/subject dichotomy, is the feature of collectivity characteristic of Memory Work. As Ingleton points out: "Just as meaning about individual experiences is constructed in relation to others in society, so the methodology explores experience in a group setting in order to make comparisons, uncover relationships, and establish typicality and plausibility" (1994, p. 266). In this way then, the group process of making meaning of the phenomenon mirrors that which each of us uses individually to understand and test the reality of our own life.

The group decides on the ‘trigger’ topics for their individual narratives, a method feature that ideally ensures that it is the participants (and not the academic researcher) who name the salient aspects of the phenomenon under study. Moreover, implicit in this agreement is the understanding that the chosen aspects are ‘common’ to the participants’ experiences of the phenomenon. The collective examines the narratives for differences and similarities, with the focus on the points of commonality between individual experiences, those “common socialising influences and practices of our society as they affect individuals rather than those which might be specific to any one individual” (Kippax, Crawford, Benton, & Gault, 1988, p. 25). The aim is to identify trends and themes in the stories that are broader than the personal and located outside the self in larger social and cultural issues.

So, Memory Work is concerned with subjectivity, not from the standpoint of individualism, but as it is manifest in specific social contexts. This approach to subjectivity involves what Schratz-Hadwich describes as “ways of thinking about the self, and changing the self, that are socially rather than individualistically located” (1995, p. 61). The identification of these shared patterns and processes enables us to understand them as the common facets of the experience. Therefore, while Memory Work requires individuals to express and share their experiences at an intimate and very personal level, the method moves participants beyond the idiosyncrasies of the texts and the tempting responses of empathy and “vulgar psychoanalysis” (Haug & Others, 1987, p. 57). Instead, the challenge is to identify the common linkages between each of the experiences.

In this collective process of analysis, the meanings derived by the group become intersubjective, in that they have been produced by the group and not just by an individual – they are ‘common sense’ meanings that have been negotiated in interaction with others (Onyx, 2000). It is interesting to note that Crawford et al. (1990) propose that this collective theorising for typicality provides the necessary tests of plausibility of the data, and therefore the base for some degree of generalisability (my emphasis). Haug goes further; she is unequivocal that in “making the research process collective, we at the same time make it possible to draw general conclusions” (1987, p. 60). In the context of this research, I do not suppose that the findings will be generalisable to the larger population; the findings are common across the trust experiences of the participants and offer insights to possible patterns of trust and gender in relationships between other groups of patients and their PHCPs. Generalisation of the findings beyond this research will have to wait for future research.

Certainly, by bringing together a group of people to research a particular phenomenon we are bringing a range of different knowledges and insights to the appraisal and theorising stages of Memory Work. This allows for the expression of multiple perspectives or truths regarding the phenomenon. The respondents get to tell their truths. But Memory Work demands that we go further than merely giving voice to respondents, or providing rich descriptions of the multiple individual experiences of a particular event within a particular context. The collective is challenged to peel off the veneer of this personal detail of our uniqueness, to reach an understanding of the “potentially generalizable modes of appropriation” (Haug & Others, 1987, p. 44) we employ to negotiate the social structures within our lives. Our experiences share

certain boundaries that are inculcated in us as part of our socialisation, and defined by the particular domain in which they occur, domains that represent the social relations into which we are born.

I found the elements of inseparability of object and subject, and collectivity particularly compelling in my choice of Memory Work as the method for this research. Other aspects of Memory Work that made it attractive to me include its twin focuses on participant reflexivity and empowerment.

Memory Work in Practice

Given that the Haug group designed Memory Work to explore female sexualisation, it is understandable that the method has been used enthusiastically for research into various feminist and gender topics. A group of Australian researchers, Crawford et al. (1992), refined and expanded the methodology to develop theory on emotion and gender. Since then it has been used to research gender and mathematical practice (Johnston, 1998a,b,c); gender and tourism (Small, 1999); gender and the study of economics at tertiary level (Ingleton, 1997); and gender and educational assessment issues (O'Connor, 1998).

Apart from use within gender and feminist studies, Memory Work has also been used for researching nursing practice (Mitchell, 1991); HIV/AIDS (Kippax, 1990); the role of emotions in learning (Ingleton, 1994); student consumption of leisure activities (Friend, Grant, & Gunson, 2000; Markula & Friend, in press); the construction of racist attitudes (Schratz, 1996); and consumer satisfaction and dissatisfaction in retail exchanges (Friend & Rummel, 1995; Friend & Thompson, 2003). It is interesting that

Memory Work is a particularly well-established qualitative method in Australia and New Zealand.

Finally, Memory Work has been used mostly by women researchers with women participants. There have been several studies that have used the method with groups of mixed gender (e.g., Friend, Grant, & Gunson, 2000; Petronic, 2001), and a small number that have used it with groups comprised of men only (e.g., Davies, 2000). As far as I know, this is the first research to implement Memory Work in a comparative gender study.

Some Issues

While it offers researchers distinct advantages, Memory Work does have certain methodological challenges and limitations. Some of these challenges were acknowledged by Haug in the 1987 document, while other theoretical and practical issues have emerged as subsequent researchers have applied and modified the method.

Destablisation

Haug's own comments on the inherent challenges of Memory Work relate mainly to the subject/object unity within the methodology. She points out that the methodology has the potential to be "disruptive and destabilizing" (1987, p. 45), because it demands of us that we question or overturn the conventional social judgements we have used to construct our identities. Observations that Memory Work is "confronting" (Farrar, 2000, p. 3), "painful" and "highly emotional" for participants

(Cadman et al., 2001, pp.4, 9) confirm Haug's comments. To reduce the destabilization effect of Memory Work, the Haug group states that it is essential that participants write and discuss their memories using pseudonyms and the third person as a way of distancing themselves. Haug suggests also that at times when an individual experiences personal difficulties during Memory Work, the group "curtail analysis and ... allow others whose personal stability [does] not seem to be endangered by specific memories to take up the threads" (1987, p. 57).

Haug stresses the importance of group members having well-developed interpersonal skills to deal with tensions in group dynamics and personality problems. Furthermore, she recommends that Memory Work groups develop "conscious collective counter-strategies" (1987, p. 45) to support individuals and maintain the equilibrium of the group when facing destabilization issues. These recommendations, formulated by the Haug group in hindsight after working together without such strategies, are reflected in Ingleton's counsel that "good facilitation and shared leadership skills are essential" (1995, p.2) so people are not hurt by the recall of suppressed memories, "testy interpersonal exchanges" or "inevitable" group conflict (Koutroulis, 1993, p. 91).

Another technique used for protecting the group against destabilisation is debriefing. Koutroulis' Memory Work group set aside two specific amounts of time at the beginning and end of each meeting to address and resolve any methodological and interpersonal difficulties. Such a strategy ensures that the group takes collective responsibility for supporting its individual members, and simultaneously would help to build the trust, reciprocity, and mutuality essential for productive group work (Butler & Wintram as cited in Koutroulis, 1993, p. 84; Cadman et al., 2001; Kippax,

1990). It seems reasonable to discuss with potential group members the implications of challenging the social construction of their individual identities, and the role of the group in supporting individuals through this process. Then, fully informed, each person can make a personal decision to participate or not.

Power

Power issues are also a major concern for Memory Work researchers. The method was designed to deliberately disrupt the traditional power hierarchy of researcher/researched, predominantly through the principles of collectivity.

Apparently, these principles are more easily applied in contexts where the women decided to form a Memory Work collective to research a topic of interest to them all, and publish their findings as a group, e.g., the Haug group working on female sexualisation (1987), and the Crawford group exploring emotion and gender (1992).

On the other hand, these collectivity principles are problematic for groups that an individual has set up around a particular topic of interest, ‘advertising’ for participants, and organising various logistical details. Typically, such groups are set up in order to complete the research requirements for an academic qualification, for example, a doctorate. It is usual in the process of such groups that the ‘student’ researcher takes responsibility for transcribing the group discussions and completing the final level of analysis where data are discussed relative to theory. The dynamics of power in these groups can be complicated. Small (1999) describes the experience of the shifting balance between power and vulnerability:

While the researcher in the present study held the ultimate power in interpretation of the findings, the researcher also felt

vulnerable ... Having the greatest investment in the research, the researcher was dependent, not only on others' interest in participation, but also on their ability to coordinate their busy lives to find a common time to meet... (p. 33)

In the earliest stages of this research, I declared the research as a project geared to fulfill the academic requirements for a doctoral degree (see Appendices A, B, C, & D). I also explained both in the written information and personal briefings that in the third phase of Memory Work I would be working individually as a sole researcher (rather than a co-researcher) to extend the collective analyses and link them to existing models and theories on marketing, gender, and trust. During the actual processes of data generation (Phases 1 and 2) I endeavored to engage in the research as a co-researcher but experienced some tension – at times considerable – between this position and that of managing the other participants and our processes to meet my requirements.

Data Ownership

A problematic power differential frequently gives rise to issues of data ownership (Koutroulis, 1996; Onyx, 2000); the ‘manipulation’ of texts and the silencing of particular ‘voices’ (Cadman et al., 2001; Gannon, 2001; Koutroulis, 1996; Small, 2000) and, ambiguities concerning authority (Cadman et al., 2001). This power differential appears to be a characteristic of Memory Work groups working in the academic context. It can be understood as the result of an acute tension between using a method that requires that we “‘go against the grain’ of research-as-usual” (op cit., p. 11), to ‘win’ recognition and status within a context still structured largely by positivist discourses. Memory Work is built on a feminist philosophy of collective

enterprise. However, our tertiary institutions demand that the research has to be our own work. In her critique of Memory Work, Koutroulis (1993) challenges researchers who compromise the method's feature of collectivity in order to achieve an academic goal and yet label their research method 'feminist'. Similarly, Small (2000) questions the right of researchers to claim that the method is feminist when it is modified to suit the topic of study and the academic requirements for higher degrees.

Nevertheless, most researchers seem content to take a pragmatic stance on the issue. These researchers continue to call the method 'feminist' on the basis that they are adhering to the feminist principles of using lived experience as valid data, and legitimising the subjective personal voice of the researcher/researched in a group where "all members are, more or less, equal in terms of the knowledges constructed" (Cadman et al., 2001, p. 8. See also Friend, 2000; Gannon, 2001).

Certainly, many contemporary researchers are aware of the tension between preserving the integrity of Memory Work, applying the method in its ideal form, and working with it as a developing methodology, adapting it to suit particular research contexts. A group of Australasian researchers who formed a Memory Work group specifically to explore some of these issues, suggest that there is a need to articulate an underlying set of principles for Memory Work, and to identify the variations which can be applied without compromising the nature of the methodology (Cadman et al., 2001). Such a set of principles and guidelines would clearly spare researchers the philosophical and theoretical angst they face if they transgress the 'rules' and 'procedures' that seem to structure the methodology at this stage. However, it is interesting to note that Haug herself cautions against rigidity in method: "What we

need is imagination. We can, perhaps, say quite decisively that the very heterogeneity of everyday life demands similarly heterogeneous methods if it is to be understood” (1987, p. 71).

Practical Issues

Apart from the philosophical problems around power issues, researchers must deal to various practical methodological problems. For example, how can Memory Work be used with men, or with groups of mixed ages or cultures? Can the methodology be used only with individuals who are sufficiently literate to be able to access, articulate, reflect on, and analyse their memories; how is such literacy ascertained? Because of the destabilisation issues, are there some sensitive topics for which Memory Work is not suited? Is a heterogeneous group preferable over a homogeneous group?

There are several serious ethical considerations that commonly arise during the Memory Work process. Anonymity is an issue that needs special attention, because of the potential implications of individuals being identified, either within the community or within an individual’s family. (Memory Work emphasizes the importance of participants using pseudonyms partly for this reason.) Similarly, researchers are likely to find themselves having to make ethical decisions regarding exploitation and the ‘publication’ of sensitive, intimate information disclosed in the privacy of the group. In practice, this last ethical concern can be addressed by detailing for the participants the ways in which the research data could be used in the future, and by ensuring that participants have the power to vet the data (e.g., Appendix D).

As with any research method, the issues and limitations inherent in Memory Work must be acknowledged and addressed by the individual researcher during the course of the research process. Judgement calls will have to be made on these methodological challenges relative to the advantages of the method, personal ontologies, and specific research aims. For the time being, such decisions are complicated by the absence of any sort of ‘formalised’ set of methodological principles and guidelines for the use of Memory Work in research conducted to meet academic regulations.

4.7 The Process of Memory Work

There are three phases to Memory Work: each person writes a memory; the group analyses the memories; and, the analyses of the memories are reappraised and related to other theories. Each of these phases is structured by a series of ‘classic’ steps based predominantly on the work of the Haug and the Crawford groups. Together, these steps and phases constitute the method that has been adopted by the majority of Memory Work researchers (Johnston, 1998b).

Phase One

This phase is centred on writing about specific memories, written according to guidelines recommended by Haug (1987):

- Write a memory
- of a particular episode, action, or event
- in the third person
- in as much detail as is possible, including even ‘inconsequential’ or trivial detail

- but without importing interpretation, explanation, or biography.

In the following sections I will discuss each of these Phase One guidelines from a theoretical point of view.

Memories

The theory underlying the use of such memories is that the recall of particular events is critical in the construction of self. Memories of lived experience are “the raw material out of which individuals construct their theories of self” (Crawford, Kippax, Onyx, Gault, & Benton, 1990, p. 335). Characteristically, events are remembered because they are subjectively significant in some way; often the recalled events are problematic, unfamiliar, or need reviewing (Farrar, 2001; Ingleton, 1995; Kippax, Crawford, Benton, & Gault, 1988). We recall and reflect on past experiences in the form of memories to construct our selves and structure our actions in the future. Thus, we are continually using memories to construct and reconstruct meaning in our everyday lives (Friend & Grant, 2001; Grant & Friend, 1997).

Our memories are our reflections and subjective reconstructions of these past events from where we are now. They are the sense we can manage to make today of past events. Our construction of any event will change over time, and hence the memory of that event will change too (see McCormack, 1998). Thus, the narratives produced in Memory Work can range from written memories of a single critical incident to stories comprising layers of memories of different occasions, collages crafted in an effort to make sense of repeated similar experiences (Ingleton, 1995; Johnston, 2001). Memory Work is concerned with the meaning of remembered events, and not with their

objective accuracy. Memory Work examines these memories for the meanings that people ascribe to events and for the processes involved in making sense of their experiences (Crawford et al., 1990; Kippax et al., 1988). Memories are a participant's particular way of representing their experience, not a complete collection of facts telling the Absolute Truth.

Narratives

In Memory Work, these memories are recounted in the narrative story form as opposed to report or myth (see Hopkinson & Hogarth-Scott, 2001). The 'narrative' is regarded as one means that we, as individuals, use to negotiate and construct reality. From a constructionist perspective, the narrative is a storytelling device we use to make sense of events and interpret our experience (Clandinin & Connelly; 1994; Friend, 2000; Gubrium & Holstein, 1998; Manning & Cullum-Swan, 1994). This perspective highlights the way we each make meaning through discourse, and allows for the analysis of the actual narrative text and deconstruction of the individual storyline, as occurs in Memory Work.

In addition, research methods that treat personal stories as narratives also facilitate the study of phenomena and processes as social constructions negotiated in our attempts to make sense of the world. In this way then, reflecting on our narratives makes possible the 're-authoring' of certain meanings we have constructed, enabling change (Haug & Others, 1987; White, 1995). It is this potential for change, inherent in all narrative methods, that casts Memory Work as a critical method of inquiry.

Trigger Topics

Some time before each Memory Work group session, each member of the group writes a memory around a trigger phrase or cue. The choice of trigger is important. The method challenges us to avoid the obvious or ready-made cues for a particular research topic, on the grounds that such a cue is likely to be firmly rooted in popular prejudice (Haug & Others, 1987) and will produce “a conventional, well-rehearsed response” (Onyx, 2000, p. 2) that does not yield any ‘new’ knowledge.

Researchers find that individual narratives are richer if the trigger evokes a description of a particular event or episode rather than an account or a general abstracted description. For example, the trigger ‘the most serious argument with your partner’ would probably prompt a more subtle and informative text from the trigger ‘arguments with your partner’, which is likely to produce an account justifying and explaining such arguments (Kippax, 1990).

Most Memory Work groups choose the trigger collectively to ensure that it is the participants identifying the common, salient dimensions of the research topic, and thereby help establish the common base of the data (Friend, 2000; Haug & Others, 1987). Other Memory Work groups write their memories to triggers given to them by the academic researcher, or chosen by the group from a list of triggers suggested by the researcher (e.g., McCormack, 1998).

The use of trigger topics to focus research efforts makes Memory Work similar to Critical Incident Technique (CIT), a method that has been adopted in several

substantive areas of marketing by researchers who recognise the value of personal experience and narrative (Hopkinson & Hogarth-Scott, 2001). Both methods have participants build their narratives around past events that are understood to be significant episodes for the individual. However, there are two crucial differences between these methods. First, in Memory Work it is the participants who collectively decide on the trigger topic, whereas it is the researcher implementing CIT who typically pre-determines the criticality of events. Second, the collective deconstructs and reconstructs the meanings of the individual narratives in Memory Work, while in CIT the analysis and interpretation of the data are generally conducted by the researcher. More details on the actual use of trigger topics in implementing Memory Work are provided in the next chapter.

Writing in the Third Person

Individual narratives are written in the third person for two reasons. Firstly, the device acts as a safety measure, enabling the individual to disengage from the remembered experience and write fully about it from the point of view of an observer. Thus, third person affords the individual some protection from what Haug refers to as ‘destabilization’. Secondly, the device makes it easier for the individual to write a description of the situation, rather than a warrant of the particular circumstances. As an observer, the individual is better able to present the detail of the event, and not get caught up in the self-justification common when the speaker is identified as the main ‘actor’ (Kippax, 1990; Stephenson, 1996). Writing in the third person frees us up to recall past events in detail and reflect on our selves of yesterday with what Haug describes as the “gaze cast by one stranger on another” (1987, p. 46).

Detail

Writing in as much detail as possible is important to help provide a base for understanding the role of social forces in our construction of events. Social forces teach us how to frame our experiences, which details are relevant and appropriate in our meaning-making, which details are to be dismissed or ignored as inconsequential (McCormack, 1998). We choose to understand our experiences according to a “dominant plot” (White, 1995, p. 29) which reinforces and perpetuates the ‘truths’ that shape our individual lives.

The so-called ‘inconsequential’ or trivial detail called for in the rules for Phase One of Memory Work, typically point to the hidden moral and normative characteristics of behaviour (Stephenson, 1996) that form the sub-plots underlying the dominant plot. As well as illuminating the dominant plot we have chosen to ascribe meaning to a particular experience, detail enables us to identify the counterplots or alternative plots that there could have been. Thus, detail enables us to recognise “the constraints placed on our understandings by the notion of ‘relevance’” (Kippax, 1990, p. 95), at the same time as it provides a ‘way in’ to explore the potential meanings of those aspects of the experience we had neglected.

Haug encourages us to concentrate on “rediscovering” the particular situation – “its smells, sounds, emotions, thoughts, attitudes” (1987, p. 47). These details usually take some effort to retrieve from memory. But Haug enjoins us to practise at having a good memory, “to make the unconscious conscious” (1987, p. 48) so that later in the Memory Work process we are better able to understand the cultural frameworks

available for making meaning of our lives. Or, as Denzin (1989) puts it: “thick description” makes for “thick interpretation” (as cited in Janesick, 2000, p. 391).

The last ‘rule’ for writing a memory-story is that we must not include interpretation, explanation, or biography. Interpretation and biography are avoided simply because they smooth over the rough edges, the absences, and inconsistencies that provide vital clues as to how the individual has constructed the meaning for that experience.

Biography brings into the text a kind of coherence, one that situates the experience on a sophisticated timeline of antecedents and consequences. This coherence hides important detail (e.g., an individual’s resistance to the cultural norms for experiencing a particular situation), and therefore limits later analysis and understanding (Crawford, 1992; Friend, 2000; Stephenson, 1996).

Phase Two

Each member of the group receives a compilation copy of the narratives written by all of the other participants. When the group comes together, each person reads aloud her/his individual narrative while the others follow the text, making notations as they like, in the compilation copy. Then the group analyses the texts for the ‘common’ sense or the social aspects of the experiences common to the group, and the processes used to make sense of them.

Crawford et al. (1992) present the following ‘rules’ or guidelines for this analysis phase:

- Each Memory Work group member expresses opinions and ideas about each memory in turn, and

- Looks for similarities and differences between the memories and looks for continuous elements among memories whose relation to each other is not immediately apparent. Each member should question particularly those aspects of the events which do not appear amenable to comparison. She or he should not however, resort to autobiography or biography.
- Each Memory Work member identifies cliches, generalizations, contradictions, cultural imperatives, metaphors,
- And discusses theories, popular conceptions, sayings and images about the topic.
- Finally, each member examines what is not written (but might be expected to be written) in the memories.
- Members rewrite their individual memories.

Looking for Meaning

In the initial stage of the analysis, when each participant is encouraged to express ideas about one of the narratives, the task is to search for meanings that have not been directly expressed by the author. So, participants question and comment to elicit details and descriptions of aspects of the memory that have been glossed over in the narrative, or missed out entirely. Participants focus on aspects of both the situation and the subjects involved.

Both the Haug group and the Crawford group advise Memory Workers to pay special attention to cliches, generalizations, contradictions, cultural imperatives, metaphors in the text, and to discuss popular theories, conceptions, sayings, and images about the

topic (Crawford et al., 1992; Haug & Others, 1987). These can conceal “the normative aspects of action” (Stephenson, 1996, p. 187). For example, in an individual narrative written about a young girl shaving her legs, the expression ‘For some reason’ stands in for a full description of what the girl experienced when she cut herself badly during her secret shaving session. The phrase covers what was likely to have been a distressing experience at the time, but an experience she ‘forgot’ as part of her female sexualisation (Stephenson, 1996). Discussion about such figures of speech and cultural ‘wisdoms’ on a specific topic, enable the group to reflect on each individual narrative relative to the cultural norms and values available to the author for making sense of the experience.

Gaps and Silences

Participants also pay special attention to the gaps and silences in each individual narrative, looking there for “the relevant traces of the social formation process” (Schratz-Hadwich, 1995, p. 48) which have been rendered invisible. Silence is one method of coping with the incompatible or unacceptable (Friend, 2000). Silences in text, therefore, can signal those points in an experience where the individual might have felt some resistance to the framework society proposes is the ‘right’ one for the situation. Participants are encouraged to talk around and about the texts until they feel that the rationalisations, explanations and justifications have been peeled away (Gannon, 2001). Throughout this part of the analysis, the focus is always on the text and participants work as a collective to grasp the details: “...researchers ask each other (not necessarily the author) for clarification of ambiguities, for more

background information on what is missing and the social role(s) of the actor(s) involved” (Schratz-Hadwich, 1995, p. 48).

Similarities and Differences

After analysing each individual narrative, the group looks for similarities and differences between the texts; in particular, points of tension and conflict - those aspects of a text which do not seem to ‘fit’ the common understandings or experiences of the other texts. Participants are looking to understand which of the subjects’ circumstances are shared, and therefore reflect common social processes, rather than those circumstances that are an individual’s variation on the theme.

Given that the aim here is to identify the commonalities between texts, participants are warned to avoid certain responses (e.g., queries that convey criticism, amateur psychoanalysis, and sympathy) which typically place the author in a defensive or subordinate position, and keep the analysis at a personal level. Rather, the participants are urged to abandon their preconceptions and prejudices, and to “adopt temporarily the same standpoint as the writer” (Haug & Others, 1987, p. 57) so that analysis occurs at a collective level. This deliberate shifting of the focus from the individual is another technique to help the group to identify patterns across the texts that demonstrate how society ascribes the meaning of a particular situation to us, as individual members (Friend, 2000).

As the participants identify common points in the individual narratives, they will begin to recognise and theorise new linkages between the points. These linkages are

“immediately recognised by the group as credible, since they ... form part of all [the participants’] meanings” (Haug & Others, 1987, p. 54). The participants check the new understandings and alternative meanings that the group constructs, both against their individual experiences and against the common experience. In this way, all the participants are co-researchers, acting both as subject and object in an intersubjective process to produce this new knowledge (Schratz-Hadwich, 1995). It is important to understand that the collective analysis phase of the process is recursive and very fluid in nature; not the linear progression which might be inferred from the ‘rules’.

Discussion is expected to move from a single narrative to the collective’s ‘common’ social sense of the experience, and back again to an individual text. As they reflect and theorise, the collective exposes the processes and “cultural knowledges through which sense is usually made of the topic” (Davies, 1994, p. 84).

Phase Three

This phase varies, generally depending on whether or not the Memory Work is being conducted as part of the academic requirements for a higher degree.

Rewriting Individual Narratives

Haug and Others (1987), the key developers of the methodology, direct the members of the group to rewrite their original narratives at this stage. Participants go into this rewriting equipped with the data and insights that have been generated during the collective analysis, and re-vise them - literally, ‘see again’ their individual experiences, this time from a different point of view. Rewriting then, “offers itself as a

step toward concretising the way in which consciousness has been altered by the group” (Koutroulis, 1993, p. 79). In their rewritten narratives, the authors articulate an alternative plot to the dominant plot they had accepted as the expected one for framing their experience. Indeed, authors can rewrite several times, exploring in text a variety of perspectives and positions until they find the discursive framework that best represents the meaning of the experience for them. In this way, rewriting the original narratives in the light of collective analysis can be a powerful exercise (Kamler, 1999; White, 1995) – Haug considers it an essential phase in the Memory Work method, necessary for both personal empowerment and meaningful social action.

Alternatives to Rewriting

Not all Memory Work groups rewrite the original memories. In some cases, the participants have chosen not to rewrite their narratives because this was not appropriate to the topic (e.g., the Crawford group’s difficulties rewriting their childhood narratives on emotion); or because the participants simply did not want to keep working on the same stories (e.g., Gannon’s group of women writers). Gannon justifies this decision of the maverick writers in her group neatly as: “The collective texts ... were the interwoven writing/reading/talking that happened around each story” (Gannon, 2001, p. 3).

When the methodology is used for higher degree research (as in the case of this research) the academic researcher generally subsumes the rewriting step into a final phase of individual interpretation and theorising of the data, completed after the group has analysed the texts. When this is the case, the academic researcher examines and

further theorises the data produced in Phases One and Two. Generally, the researcher critically examines the themes and common sense understandings that the participants arrived at, relating the collective's knowledge to other theoretical positions and other kinds of research to modify and build theory around the topic under study (Crawford et al., 1992; Friend, 2000).

4.8 Concluding Comments

My research interest focuses on the interaction of trust and patient gender in the service provider-consumer relationship within primary health care settings. As a researcher I believe that theory must embrace experience as a legitimate base for knowledge. My worldview allows for a range of personal realities and the right of individuals to live lives marked by diversity and tolerance – society's wealth lies in this plurality. I believe that we come to understand our experiences through our own processes of inner reflection, and testing our 'meanings' with others.

Given the research focus and the nature of my worldview, I sought a method that would enable me to represent patients' experiences of trust, using a research process that would hear and respect the meanings that they themselves ascribe to those experiences. As a researcher I needed a method that would engender an environment of respect, trust, sharing, reflection and growth. I have chosen to work with Memory Work because its philosophical assumptions and methodological focuses on experience as a theoretical base and on the co-creation of knowledge, fit so closely with my personal worldview and research objectives. I have discussed the parallels between my ontology and epistemology and the Memory Work method in this chapter. I have also outlined the method's limitations and briefly explained its process

from a theoretical perspective. In the next chapter I provide full details of the Memory Work method as I applied it in this research project.

5: Implementing Memory Work

“Human beings produce their lives collectively. It is within the domain of collective production that individual experience becomes possible.”

(Haug and Others, 1987, p. 44)

5.1 Introduction

The purpose of this chapter is to detail the step-by-step processes that I undertook in conducting this research. In the last chapter I discussed Memory Work generally, as one of the qualitative means of gathering data that is underpinned by a particular philosophical orientation, which will impact both on data collection and interpretation. In this chapter I discuss Memory Work specifically as it worked in this particular research situation to help us understand more fully what trust meant for the male and female patients in their primary health care encounters. I detail the practical processes of data collection, then discuss the ethical issues that were considered throughout the research, and finally identify the advantages and limitations of Memory Work as the method chosen for investigating this research topic.

I use excerpts from my research reflections to tell My Story as it was happening at the time. This stage was tumultuous, the time of most challenge and growth for me in the entire research journey. My emotions ranged from feelings of awe and humility, to fear and despair at my naivete and inadequacies. I have chosen reflections that provide details of the ‘history’ of this stage, including my responses both to the high

points and to the speedbumps and dead-ends I hit along the way. I also present the excerpts that best explain the actual course of my decision-making during this phase, because of the implications these decisions had for the data, and for the participants and me as the humans directly involved.

My intention in incorporating these reflections is to produce a chapter that is a more vital account of the data collection process, and thus to better equip you to assess the degree to which I was reflexive and self-critical in my role as a developing researcher. Rather than appearing in a separate section called ‘In My Own Words’ at the beginning or end of the chapter, it seems more appropriate to scatter these reflections throughout the chapter, marked by a bullet point and appearing in italics, to ensure smoother integration with the text. Finally, my aim for this chapter is to produce a clear, transparent, and fully detailed audit trail through the research process in the interest of establishing the trustworthiness of our work.

5.2 Memory Work as the Method of Choice

It is helpful to regard the method as a certain array of research techniques, or ways of gathering data, that the researcher has determined is the most suitable to use with the particular group of people who are best able to answer the research question. This understanding enables us to make responsible strategy and method decisions relative to the purpose of the research, the nature of the research question, and the skills and resources available to the researcher (Morse, 1994).

From this standpoint, the important reasons for choosing Memory Work as the method of inquiry included:

1. This research concerned the meaning of the trust phenomenon. Memory Work comprises principles of phenomenology “in that it seeks to obtain, through a self reflective analysis, that which is conscious to an individual regarding her/his lived experience” (Friend, Grant, & Gunson, 2000, p. 25). This made it an ideal method of inquiry for achieving my research purpose and answering the research question, as stated in Chapter 1: “How do male and female patients perceive and describe their experiences (both positive and negative) of trust in primary health care practitioners (PHCPs)?” In addition, Memory Work would enable me to explore the trust phenomenon fully, within the parameters for this research stated in Section 1.5 of Chapter 1.
2. I was able to work with Memory Work confident that I had adequate personal and practical skills to implement the method productively (e.g., interpersonal skills, interviewing experience, technical skills, organizational skills).
3. I could implement Memory Work within the boundaries imposed by the resources available to me with the minimum of logistical problems (i.e., without fuss!). I could hold the groups either on campus, or in my own home (either way, without ‘cost’ to the care of my children); it did not require complicated equipment; and the expected financial costs of conducting the research with Memory Work fitted within a research grant that I had been awarded.
4. Memory Work is flexible by design. This was important to me on a philosophical level – I needed a method that could be adapted easily as required, in the interests of generating trustworthy qualitative data that were as rich in detail as possible.

Thus, Memory Work fitted well as the method of choice within the qualitative research strategy I had determined was most appropriate for this research.

5.3 Data Collection Circle

Although the following sections detail the implementation of Memory Work in this project as separate activities, data collection did not happen in a clear, predictable linear sequence. Typical of any qualitative research, this study was an iterative inquiry process, and data collection involved moving in and out of a series of interrelated activities all aimed at gathering “good information to answer emerging research questions” (Creswell, 1998, p. 110). So this phase is best understood as the ‘circle’ of data collection activities conceptualised by Creswell rather than a clearly delineated sequence of events that the following structure might suggest. However, in the interests of clarity and comprehension I detail the main procedures of the data collection phase in separate sections, under the general headings of Participants, Data, and Procedures.

Participants

Sampling Considerations

The sampling in this research (as in any qualitative inquiry) was driven by the aim of illuminating the phenomenon of trust and increasing the scope of data we have available to us. Within the general parameters for the study, participants were chosen

using a criterion sampling, a particular purposeful sampling strategy (Creswell, 1994; Miles & Huberman, 1994).

As with phenomenological studies in general, the participants in this study all had to be individuals who had experienced trust (positively or negatively) in primary health care practitioners, and could articulate their experiences (both in written form and verbally). Because the research was to use the Memory Work method specifically, the participants all had to be capable and comfortable discussing their health care experiences as part of a small group. The criterion that participants be comfortable articulating their health care encounters aimed to produce data that would support rich descriptions, analyses, and interpretations of their trust experiences.

Accessing Volunteers

I began this stage by advertising on campus for men and women to take part in the research, on the topic of “Gender and patients’ trust in their doctor (General Practitioner)”. See Appendix A. Because of the sensitive nature of the topic and the possibility that participants might need to discuss their experiences with a trained counselor as a result of participating, I specified that volunteers must be employed by the University of Waikato. This criterion ensured that we would be able to use the counseling service that the University of Waikato provided to staff, free of charge. Later, I amended this requirement to include students, when it seemed that we could also access free counseling for students; and finally I accepted volunteers from off the campus who were willing to take responsibility for any additional counseling care they might require.

This first advertisement for volunteers also advised people that they would need to be able to write about their experiences and be comfortable discussing them in a small group. The ad also told people that they would work in a group with others of the same gender, and similar ages and social/cultural backgrounds. The rationale for these decisions will be discussed later on in this section.

I made 80 copies of this first ad, poster size (gold paper – bright and positive) and took them around myself to all the departments on campus, talked to the department secretaries and/or administrative assistants about the research topic and the poster, and asked to put a poster up in a ‘public’ space within the department, for example, the mail room or the photocopying/printer room. Some heads of department took as many copies of the poster as staff in their department and said that they would post one into each staff member’s pigeonhole. I also posted the ad in staff-rooms and on department noticeboards. Within a week six women responded to the poster, two of who became participants. No men responded. And I discovered that I was totally unprepared for this turn of events.

After I had distributed the poster I also began to personally approach women whom I thought met the participant criteria, and asked them to consider taking part in the research. I also asked them to recommend or speak to any of their colleagues whom they thought would be interested in the study (‘snowballing’). Two more female participants were located this way. Counting me as a participant we now had five women - enough for one research group. Before I had started this access stage, I had decided that because of the time constraints I was going to have to limit my research

to four groups only, two of females and two of males. Now, more than one month after the posters went up, I was noticeably humbler and very grateful to have four women (apart from myself) willing to participate.

But still no men. This was not a good look for a comparative gender study. I talked to my supervisors, to friends and colleagues, to a sociology professor, a psychology professor, and my Dad.

- *In My Own Words: Talk to Dad about accessing volunteers. Trying to get a sense of how to engage the interest of males in the research ads, and subsequently in the Memory Work. Dad explained that for many men (particularly of his generation) breakdown in health was perceived as weakness. Having to go to the doctor was even worse! Have had a sense of this for a long time but previously had never really taken it on board. Had almost dismissed it as an over-reaction, a sympathy call, an excuse – how could it possibly be true? Men these days are educated, aware, in control of their own lives!*

This time I got it. Me and Dad. I had asked him specifically to tell me the truth, not what he thought I wanted to hear. My Mum and my children were away. A window in time. And in getting it, I learned I had to step out of my shoes, and into his. Properly. No token gestures. No lip-service. Started to understand the power of socialisation. For how long are the 'sins of the fathers' visited on the sons?? How strong is this macho attitude to illness/GPs for subsequent generations??

After: I have learned about honouring the confidences invested in me by others. And learned empathy. Gentleness. And humility too.

In this consultation process I began to realise that what I might be dealing with here was a gender effect, which to overcome would require some adaptation of the original access strategy. Access Plan B began to take shape. I decided to stay out of the public places – the tearooms and photocopying rooms – and go small, discreet, and private with an ad in our university's staff magazine *On Campus*. I rewrote the poster to make this ad warmer and more user-friendly (see Appendix B). No response.

A third ad was written. This time the ad was to be run in the university's electronic events e-flyer. By now my strategy advisors also included an expert in gender studies, a marketing strategist, and one of the university's experts on teaching and learning. I was also consulting, on a more personal level, with assorted sympathetic males. As part of this new access plan I broadened the service-provider category from that of the original, GPs only, to all primary health care practitioners. I had realised that because New Zealand males were known for not having deep or lasting relationships with their GPs, and because New Zealand males were notoriously reluctant anyway to talk about sensitive issues such as their health problems, then I had to make the topic less restrictive in an effort to generate a response from men.

I wrote the ad very carefully, removing fuzzy words like 'trust' and 'relationship' from the text. On the advice of the marketing strategist (who also lectures in personal selling) I left out of this ad any specific details of the Memory Work method, for example, that it involved group work and writing about personal experience. This plan aimed to engage the men's interest enough to have them phone me, at which point I would make a time for a face-to-face meeting when I would proceed to sell them the chance to be a part of this research.

The ad went into the events e-flyer (see Appendix C). Three men responded to it. A fortnight later the ad went in again. Two men responded to it and one woman volunteered her husband. No men signed up. I was left with two choices: Give up on men entirely or come up with yet another plan. As a qualitative researcher I could feel myself becoming more resilient, more determined, and decidedly flexible.

‘Marketing’ the Research

Applying both marketing and gender concepts to the whole experience so far, I came to understand that my ‘product’ could well be regarded by New Zealand men as very high-risk (perceived personal risk, ego risk, social risk, time risk), and might actually involve a considerable gender stretch for them. From a marketing perspective, the most effective promotion for such an offering is Word of Mouth. So I abandoned the ad approach and concentrated solely on strategic snowballing – identifying likely prospects, talking through the research project with them, and asking them to identify any males they thought might be interested.

In the three months between that first poster-call for volunteers and having the final participants sign, two of my supervisors also initiated their own snowballs – talking to colleagues and writing emails to those on their own professional networks. Altogether I spoke to a total of 22 people who were interested in the research project, accessed either by myself or by my supervisors. All 22 received a Research Information Booklet (see Appendix D). Subsequently, I met face-to-face with 19 of these people to

discuss the research in more detail. Eight of these final 19 volunteers agreed to participate.

Final(ly!) Participants

Three months after the poster ads went up I had a group of four males sitting around my dining room table ready to do Memory Work. All of the men had been accessed using the personal approach. Two of these men were academic staff. One was the husband of a female participant and worked off campus for a local body authority; she had ‘volunteered’ him. The fourth male participant had arrived at my home squeezed into the back seat of a two-door sports car taking us to a Blues concert, and had volunteered by the end of intermission. He also worked off-campus. The sampling criterion that volunteers must work on-campus was dropped and, on their written agreement to take responsibility for accessing counseling help should they need it, the two male volunteers from off-campus formally became research participants.

All participants met the general research criteria. First, they had experienced the phenomenon being studied: trust. They all reported that they had experienced trust (positively or negatively) in primary health care practitioners. Next, they were confident they could articulate their experiences, and were comfortable knowing that they would be discussing their experiences as part of a small group. Moreover, they seemed interested in taking part in the research; were willing to donate lengthy periods of time to participate; and gave me the right to tape-record, and publish their experiences in the PhD thesis and other publications. Thus, they each seemed to answer the description of a ‘good’ qualitative informant put forward by Morse (1994)

as “...one who has the knowledge and experience that researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study” (p. 228). So, on the basis of these sampling criteria the participants were homogeneous. But there was a range of difference between them on other personal characteristics.

At the time of the research, the five female participants ranged in age from 31 to 47; four had degrees and one was doing undergraduate study; one had spent her childhood in Fiji and Malaysia, one had been born and raised in the United States, another had lived and worked for 15 years in the States, the remaining two women had grown up in New Zealand. The four male participants were aged from 30 to 60; three had degrees and one had various courses from tertiary institutions; three were born and raised in New Zealand, one was born and brought up in England. Such diversity in Memory Work participants was regarded as an advantage by Haug: “the more diverse the backgrounds and present occupations of members of the collective, the more far-reaching the insights gained into socialization in general” (Haug & Others, 1987, p. 58).

Heterogeneity, in fact, ensured that these participants would bring to the research different perspectives and a range of sites, activities, processes, events, locations, and times when they had experienced trust in primary health care practitioners. In effect, the heterogeneity enabled us to compare the trust experiences and therefore generate a more compelling and powerful understanding of what ‘trust’ meant for these men and women in their health care contexts (Bogdan & Biklen, 1982; Creswell, 1998; Hodder, 1994; Huberman & Miles, 1994).

To summarise: This research involved two groups of participants, one comprising four males and one of five females. (For profiles of these participants and a self-reported statement of their health status, please see Appendix E.) All participants lived in Hamilton, a city of more than 114,000 people (at the end of 2001) in the North Island of New Zealand. All of the women and two of the men worked or studied at the University of Waikato. Two men were employed off campus. I worked in the role of facilitator with the men's group, and joined the women's group as a participant. Finally, while the sample was small (by quantitative standards), included some participants who knew each other before the research began, and could be said to be largely homogenous on characteristics such as education and age, I was satisfied that there would be greater benefits for the groups because of these factors than there would be limitations. The aim of this research was to gain meaning and an in-depth understanding of the trust in PHCPs and its interactions with gender, not to test a theory across a population. Therefore, I was concerned with facilitating groups that would feel comfortable and safe for the participants, and therefore support quality data; generalisability was not an issue.

Procedures

This section summarises each step used to conduct the research. While these steps are detailed separately, it is important to remember that they are recursive in practice – they merge together in the one process and are not as easily distinguished in reality as the following discussion suggests.

Preparations

First Contact: This initial contact with a volunteer generally was made by phone or email. The main aim here was to check whether or not the caller had experienced trust (positively or negatively) in primary health care practitioners, and was able to detail and discuss these experiences with a group. Once I had established that the caller met these research criteria then I asked for postage details so I could post off an information pack, consisting of a Research Information Booklet (Appendix D), a covering letter (Appendix F), and a map of the campus showing the location of my office. I explained to the caller that I would be posting out full details of the research so that they could decide quietly for themselves whether or not they wanted to participate, and that I would contact them within a few days to discuss the research with them. I also asked the caller to pass on the research details to any of the people they knew who might be interested in taking part.

Second Contact (either by phone or email): The agenda of this contact was set by the volunteer's response to my question: "Are you interested in getting together to discuss the research in more detail?" If the answer was affirmative, I made a suitable time to meet the person in my office on campus (allowing an hour), checked that they understood where my office was, and asked them to bring with them their research information booklet.

Personal Meeting: This was an important meeting. On a practical level it gave the volunteer the opportunity to ask any questions or clarify points made in the research information booklet. During the meeting I was able to reiterate the main points of

anonymity, confidentiality, safety issues; and make sure that the volunteer really understood the commitment required of participants. I emphasized that the research data could be used for publication, but also that they had the right at any time to decide that certain contributions not be used. We discussed the volunteer's literacy skills; their experience working as a member of a group; and their relationships and trust experiences with primary health care practitioners. This face-to-face meeting also gave each of us the chance to get "a feeling" for the other, as well as for the research project.

Towards the end of this meeting, if the volunteer seemed to be suitable and providing they were keen to take part in the research I gave them a consent form and a time/venue sheet on which they could indicate their preferred session times. Volunteers were free to complete these forms in the office or take them away to consider and fill out in their own time.

Group Briefing: This was designed to allow the volunteers to meet the others in their group, and to go over the research project and Memory Work method. Volunteers introduced themselves and talked a little about their interest in the research. We decided on group safety rules (what we needed to be able to talk and work safely in this research group), and then discussed very generally trust experiences (positive or negative) with primary health care practitioners (e.g., the situations in which we have or have not trusted primary health care practitioners; why patient/practitioner trust is important).

During this discussion I made a list of key phrases from the comments, which helped the groups formulate the trigger topic for their first narrative. With a topic set, I then took the volunteers carefully through the guidelines in the research information booklet for writing a ‘memory’ or narrative. As an example, I also gave each person a set of narratives written by participants in other Memory Work research. The briefing ended with arrangements for getting the narratives to me, and confirmation of the time and venue for the first session. I recorded this briefing, to test the recording gear, and to help the groups get used to working with it too.

The women’s briefing was held on campus, in a different room from the one we would use for the group sessions. The briefing room was a small tutorial room, with the furniture set up in a traditional teacher-student configuration – not surprisingly, I found that I took a ‘teacher’ role throughout this briefing.

- *Women ended up sitting in front of me as though they were in a lecture, with me the lecturer; and because of the furniture I felt unable to get into a better position – I was blockaded by two long desks and several chairs (the entire room had too much furniture in it, and it was very difficult to move it around at all). Also had nowhere to use the large paper I had brought with me for brainstorming. No whiteboard markers on me; none in the room; and the blackboard was not in the right position for the way we were sitting in the room.*

I was not prepared – had not prepared the space physically. These participants deserved better – they were coming into an ‘unknown’ situation (first time meeting all the other respondents; the method), and had made a huge commitment.

The men met for their briefing at my home, at the same time as their sessions would start. We met around my dining table, an eight-seater, in a room with windows and garden on two sides and not a blackboard or overhead projector in sight. Both the women's group and the men's group decided on the venue for their sessions on the basis of convenience. For the women it was easier and more convenient to meet on campus, during working hours because it caused less disruption to family life than getting together for three hours some time in the evening or weekend. For the men, it was easier and more convenient to meet during the weekend (Saturday afternoon), out of working hour, and to help make the sessions as relaxed and comfortable as possible they used my home as the venue (rather than one of the rooms on an empty campus).

Data

The women's Memory Work sessions ran during the months of October through to mid November 2001. We had five sessions altogether, each lasting for at least three hours. Throughout this period we wrote 23 narratives (two absences due to illness), ranging in length from four pages long to less than a page (single-spaced), and generated 291 pages of transcribed discussion during our sessions. Our work was focused on the following trigger topics, decided collectively (the women's and men's groups chose the trigger topic for their next session at the end of each session):

1. "The most important time I have trusted a primary health care practitioner."
2. "Describe a time when your primary health care practitioner demonstrated that s/he was worthy of your trust."
3. "Being vulnerable."
4. "Describe a time when you experienced a break-down in trust in your primary health care practitioner."

5. “Describe the time when reassurance from your primary health care practitioner was crucial.”

The four men met for five sessions also, over the months of October to December, 2001. Their sessions also ran for at least three hours. The men produced 20 narratives altogether, and 317 pages of transcribed discussion. The topics they chose to centre their work were:

1. “Risking a visit to an alternative primary health care practitioner.”
2. “The first visit to a new GP.”
3. “An urgent encounter with a primary health care practitioner.”
4. “Challenging a primary health care practitioner.”
5. “Describe a time when I consciously sought to influence trust with a primary health care practitioner.”

As the ‘memories’ central to the Memory Work method, the narratives were accounts written from memory about a particular episode, action, or event, chosen by each person to fit the topic prescribed by the group. Each person wrote using a pseudonym and in the third person. Following the method guidelines provided, participants wrote one of their most vivid memories on the trigger topic, and included as much detail as they could remember (e.g., sounds, smells, sights, people and their behaviours, and the discussion that occurred). Participants were told to include in their narratives both the key images they recalled from the situation and any details that they might have regarded as trivial or inconsequential. As expected, the narratives typically were descriptive, with little interpretation or explanation.

However, it is important to note that while the guidelines for writing the narratives urged participants to write without biography (personal details or past events relating to the situation being described), this proved problematic in this research. Participants found it was difficult to write full descriptions of their trust experiences with primary health care practitioners without including vital biographical details, usually regarding their health history or their relationship with the practitioner. Health conditions frequently develop over time, as do trusting relationships with professional service providers.

In Denzin's (1989) differentiation between thick and thin description I found the theoretical support I needed to relinquish this methodological guideline. Every person brings an individual history and personal biography to the phenomenon under investigation, that will have shaped, influenced, and constrained that person's experience of the phenomenon. Denying the historical or biographical dimensions of an experience would have resulted in a narrative consisting merely of thin description, one that simply reported facts, independent of the circumstances that surrounded the experience. On the other hand, one of the distinguishing features of thick description is the way "it traces the evolution and development of the act" (Denzin, 1989, p. 33). I was aiming for thick descriptions of these trust experiences, so I chose not to follow this guideline of excluding biography. Indeed, I would challenge such a guideline in any interpretive method, given the interpretive insistence that each human being exists as a historically and culturally located individual.

Participants wrote their narratives on their computers and then emailed them to me or gave me a paper copy, or else wrote the narrative by hand and I word-processed them.

Then, using a standard presentation style (all the same font, size, layout, heading style), I collated the narratives into booklets for each session, one copy of the booklet for each person. These individual narratives of their personal experiences (the ‘memories’ of Memory Work) constituted one type of data collected over the course of this research.

I printed off a hard copy of each narrative in the form the participant had emailed it to me (i.e., before I formatted it for the group collection). This original copy was filed and secured in a locked filing cabinet in my university office. Similarly, any original scripts of narratives written by hand or word-processed and delivered in paper were filed and secured. Copies of all the narratives were also saved on computer disk and hard-drive.

- *In My Own Words: Wonder about my right to change the format and type of the original documents to a standard 12pt Times New Roman, double-spaced format – what clues are being lost in the conversion? E.g., Jimmy (the ‘Clown’ of the men’s group) used Comic Sans MS for his narrative. What is lost in sanitizing the narratives like this – there seem to be no guidelines, no protocol within the method for this – could the researcher simply photocopy the original of each person’s narrative? Or is it another way of depersonalising the narratives so that the participants can analyse them productively? In which case such sanitizing could be seen as another technique to reduce destabilisation.*

A second type of data was generated by the group work. The sessions, when participants collectively remembered, compared, and theorised the individual

experiences, were recorded on audiotape and then transcribed. Their discussions aimed to reveal the social construction of the meaning of patient trust contained in each narrative, first by analysing each separately, and secondly by comparing the narratives with one another. Following the guidelines for Memory Work (as detailed in Chapter 4, and provided to participants in the Research Information Booklet, Appendix D), at this stage of the method the group worked to ‘thicken’ up the written description of each of the individual narratives by conducting a ‘textual analysis’: examining and adding detail to the account of the events that occurred and the relationships between characters in the narrative, looking for clichés and contradictions, statements made and silences created.

The group also conducted ‘cross-sectional analysis’ of the narratives: looking for similarities, differences, themes and common patterns across the texts (see Willig, 2001, for a full discussion of the analytical techniques employed in Memory Work). Thus, the data represented by the session transcripts are the ideas, analyses, and theories produced by the group – the co-researchers and the experts in these trust experiences - in relation to the social constructions of trust located within the individual narratives.

Each session was recorded onto two dictaphones, as security against some technical or operator failure, and also, so that one tape could be set to record the conversation missed while the other was being changed.

- *In My Own Words. Men’s Session 2: Dictaphones – hate them with a passion.*
Finished the session on a huge high, went to check the tapes, and it appeared that I had nothing on either side of the Tape 2s. The bottom fell out of my world. Could

not believe it. Went back for a gentle little check when I was fit to, and eventually discovered that I had actually recorded on one side of the Tape 2s, and one side of an extra tape (Tape 3s) which gave me the necessary 4 sides. Went to bed brain-dead and physically exhausted. Rang Suzette, who suggested that I draw up a recording sheet and tick off the tape changes – Tape 1, side 1; Tape 1, side 2, etc., etc., - will do this the next time. Also put reminders on the sheet to check the connections, battery lights etc.

- *Women's Session 3: Forgot (!!!!!!!!!!!) my session plan. I had worked late at home on this the previous night, and copied it onto a disk so that I could print it off first thing on Tuesday morning, but I forgot to do that. Also, forgot my Tapes Checklist (!!!!!!!), also carefully designed the previous night. Subsequently, suffered through a heart-jolting check of the tapes after the session to find a blank tape, which on investigation turned out to be a blank side as I have done in the past. I am absolutely devastated by the whole taping process – I hate it and would like to get it sussed so I can relax on that score. At the moment it is a huge source of anxiety for me – terrifying and exhausting.*

The audiotapes were transcribed by a reputable transcribing service based on campus. At all times they were not in use, the audiotapes were secured in a locked filing cabinet, either in my office or in the offices of the secretarial service.

The actual booklet of narratives used by each participant during the group work constitutes a third source of data for this research. Participants made notes on their booklet of narratives throughout the sessions, and all gave me permission to have their copies (rather than keep them themselves, as originally set out in the Research Information Booklet). These notes range from lines made beneath certain words to

fully constructed questions recorded in the margin and waiting to be asked. I believe these documents offer a potentially valuable source of data that has previously not been explored either in Memory Work research or in qualitative research in general.

Finally, I have used my Research Diary as data. I began the diary at the beginning of the data collection phase to provide an account of my research activities and contact with participants, and details of the data collected. I recorded the reactions and suggestions of my supervisors, as well as the comments from other people with whom I consulted throughout this phase. At this time I also began a Reflections journal to chronicle my experience of the research process, with entries organised loosely into four categories: observation notes, methodological notes, theoretical notes, and personal notes. It provided me with a private means to ‘de-brief’ honestly, enabling me to express, explore, and develop the feelings and thoughts which arose during those months, and which contributed to how the research took shape. This journal turned out to be a very valuable research tool and I have used it as a fifth source of data. Taken together then, these five sources provided the data for developing a ‘thick’ understanding of what constitutes ‘trust’ for male and female patients of primary health care practitioners.

Throughout the data collection phase, I followed various qualitative protocols designed to ensure dependable and trustworthy data (Creswell, 1994; Gilchrist, 1992; Hodder, 1994; Huberman & Miles, 1994). I regularly recorded details of the development of the research and personal progress, and endeavored throughout to reflect mindfully and articulate researcher ‘bias’. Data were collected from multiple sources and theorised by multiple analysts (the participants), identifying the common

patterns and themes from the perspective of these patients, and disconfirming evidence of individual variations on their trust experiences. Participants engaged in multiple sessions (compared, for instance, to a single interview) over a prolonged period of time. These features facilitate data triangulation, as outlined by Denzin (1989), Janesick (1994), and Fontana and Frey (1994). The participants were involved in determining the final data collection procedures and in checking the interpretation of the data. This verification occurred at different stages throughout the research - during each session, at times with individual participants after the group interaction, and then when I sent participants a copy of the chapters in which I had written up their data.

Data Collection

Memory Work Sessions: One week after their briefing, each of the research groups met for their first Memory Work session. During that week each person had written a narrative on the group's trigger topic and passed it on to me in time for me to collate the narratives and prepare a complete set for everybody.

Generally, sessions followed this format:

1. Welcome.
2. Congratulate participants on their work (e.g., their narratives, previous discussions), and/or remind them of the value of their contribution to our understanding of patient trust.
3. Debrief – on the narrative just written, anything that had come up from any of the previous sessions, or the method itself.

4. Session Focus. Before the other participants arrived I would have written in large letters a series of focusing questions for each session. (On the whiteboard in the classroom for the women's session, on a large sheet of paper that I then stuck onto the window at the end of the dining table for the men's session.) These questions served as simple reminders both of the overall goals of the research, and the topic we were exploring during any particular session. For example, the focus questions I wrote up for the Women's Session 5 were "Research Focus: Exploring how we as female patients experience trust in primary health care practitioners. Feelings? Thoughts? Behaviour? Physiological reactions? Today's Focus: Reassurance – how did you experience this? How does reassurance relate to your trust in your practitioner? How has it happened that you experience reassurance/trust this way?"
5. Method Reminders: For a few minutes we would go over the guidelines for writing our narratives or techniques for analysing our experiences, depending on what was most relevant to the group at that time in their work.
6. Analysis: Each person was given a booklet of the individual narratives at this point in the session. The group would decide the order in which the narratives would be read, and the first participant would begin. Generally, one participant would read her/his narrative, the participants would "interview" for any extra detail they required and analyse it as a text. Then the group would move into cross-sectional analysis of the narratives, concentrating on those facets of the narratives that transcend the idiosyncrasy of the individual experiences and were common to all the narratives.
7. Summary: At this point, the participants spent about 20 minutes summarising the main points of the narratives and the group work for that session, and then

concentrated their discussion on exploring the links between their trust experiences and the social processes that shape them. I introduced this 'Summary' time to the format at Session 3 for each of the groups, after I became concerned that neither group seemed to have reached this stage in the methodological process during their first two sessions.

8. Trigger Topic: Group chose the topic for their next narrative.
9. Debrief.
10. Thank You.
11. Goodbye.

Between Sessions: Both groups met every two weeks, apart from once when the women decided to have their final Session 5 just one week after the last, to make things easier for a participant who, with her young children, was due to fly to America the day after the last scheduled session.

The time between sessions was filled with writing my next narrative, debriefing with my supervisors and journal, reflection, planning, and organising for the upcoming session, and processing the next group collection of narratives.

- *In My Own Words. Women's Session 4: Had been over the narratives and actually made notes – questions, etc., the night before (the first time I had done this). But also, had not made a session plan, part of me was stuffed and didn't want to, part of me decided to just be spontaneous and go with the flow – I had scripted the men's session on the Sunday before quite heavily, had been unable to remember everything I had wanted to say, felt poxy about that, and had an awful session*

overall, mainly because I attempted to claim far too much control over the whole session. I was still recovering from this session when I was preparing for the women's – so can understand the tiredness, lack of enthusiasm, reluctance to prepare in detail as part of my reaction/recovery from the previous men's session.

Participants aimed to get their narratives to me a couple of days before the next session, so that I had plenty of time to format them and collate them into a booklet (see Appendix G, for an example). Due to unforeseen circumstances though, on a couple of occasions this did not happen. One of the women ended up bringing to the session enough copies of her narrative for all the group members, and one of the male participants emailed his narrative through to me 25 minutes before the session started. (At times like this I found myself waging war between the desire to be a flexible qualitative researcher and rising levels of stress built on the urge to take full responsibility for managing the research process.) Between sessions I kept in contact with each of the participants, acknowledging receipt of their narratives and sending them emails to confirm the trigger topic, date, time, and venue for the next session. All contact with participants was detailed in my research diary, and all emails printed out and filed.

Data Analysis

Collective Analysis: The participants analysed the narratives at two levels. They worked at a textual level in their discussion of such features as cliches, contradictions, metaphors, and inconsistencies in the individual narratives. One of their aims was to enrich each narrative, identifying gaps or glossed-over points and eliciting more detail

as required to ensure that the narrative was as vivid and full as possible a description of the experience. This stage was focused on building a clear, comprehensive picture of the nature and meaning of trust for each participant in each of the given situations. Participants were working to answer the “what” questions contained in each experience. (For example, “What is going on here?” “What is trust for this person in this situation?” “What is the person feeling/thinking?” “What are the person’s actions in this trust experience?” “What are the social relationships involved here?”)

Once the group was satisfied with the depth of detail of the individual narrative, then it was able to move to analysing the narrative. Now the aim was to answer “how” questions connected with these gendered experiences of trust – understanding the underlying social structures that account for the experiences being what they were for each of these men and women. (For example, “How did this trust experience occur like this for this woman/man?” “How did s/he come to inscribe these meanings in this trust experience?”)

From a theoretical point of view, the aim of analysis at this first level of Memory Work was to reveal the social construction of meaning contained in each memory. Analysis was focused on uncovering how each of the participants had made sense of their trust experiences, the social processes involved in constructing the meaning of ‘trust’ in each instance (see previous chapter for more detail; Crawford, Kippax, Onyx, Gault, & Benton, 1990; Haug & Others, 1987; Willig, 2001).

At the second level of analysis, cross-sectional analysis, the participants worked across narratives looking for the similarities, differences, recurring themes, and

common patterns among the narratives. At this level, the aim was to explore the pool of memories for the social relations and cultural meanings common to the experience of trust for the males and for the females in these two groups (refer to previous chapter for a full discussion. See also Crawford et al., 1990; Haug & Others, 1987; Willig, 2001).

Extending the Collective Analyses: The third level of analysis, my extension of the collective analyses, involved critical re-appraisal and further theorising of the data produced by the groups. I saw my role at this stage to continue the work of the groups, following the directions indicated by these experts on this phenomenon, linking their ground work to existing models and theories on marketing, gender, and trust, in order to provide theoretical support for their explanations and thereby extend our knowledge of the gender and the experience of trust. I chose not to use coding software (e.g., Nudist) for analysis. I did not have the computer skills necessary to make it a more efficient option. Nor did I want to forgo the pleasure of doing this stage myself – as a researcher I loved working with the data, sorting, sifting, shifting, and connecting.

Before I began the task of extending the collective analyses, I played through the audiotapes for each session, checking the transcripts (in Word document form) as I listened. The purpose of this was to “clean up” the transcripts – correcting words that had been transcribed incorrectly, inserting words that transcribers had been unable to decipher, checking that all identifying names of people and places had been replaced with pseudonyms, and correcting any discussion that had been attributed to the wrong

participant. While this was a very time-consuming project I was always conscious that during the time I was cleaning I was thoroughly 'immersed' in the data.

Next, each transcript was formatted with line numbering and printed out. I kept one copy as the master copy and used the other as a work copy. Then, I read through each transcript once without making any notes; next I reread the transcript highlighting significant words and passages (relative to the research questions), and noting in the margin any initial thoughts I had at that time. For easy identification I then ruled lines down the right hand side of each page, the number of lines corresponding to the session number (e.g., the transcript of the women's fourth session had four lines ruled down the right side).

Finally, I made two more copies of each transcript, these for cutting and pasting, and prepared to photocopy any extra copies as I needed them. The women's transcripts were all printed on yellow paper, the men's on grey paper. (The colour decision was made for me by the secretary who informed me that these were the only two colours the department had spare, thus saving me from the pink-blue dilemma!)

Critical Re-Appraisal: My critical re-appraisal was based on principles of thematic analysis (Crawford, Kippax, Onyx, Gault, & Benton, 1992; Owen, 1984; Zorn & Ruccio, 1998). I cut and pasted each of the marked passages onto a new page, carefully developing the initial coding by double-checking and developing instances of recurrence, repetition, and forcefulness as the criteria for thematic analysis. I recorded my thoughts in the space beneath each clipping, and cross-referenced each instance to other separate but related passages.

At the same time I referenced each clipping in a large scrapbook, assigning each to the topic(s) or category it applied to e.g., ‘Thoroughness’. These categories, in turn, were entered under broader headings e.g., ‘Positive Qualities in Primary Health Care Practitioners’. Finally, I photocopied these scrapbook pages, cut out the categories, and physically played with them until I was satisfied that I was developing connections according to the group’s working analyses. Then I was able to concentrate on developing the more abstract themes that these categories characterised. I followed this procedure systematically, separately for the women’s data and the men’s data, to explore the participants’ analyses of their experiences of trust, and then, to extend the themes that emerged in the group theorising of their experiences.

This stage of the analysis ranged across both the individual narratives and the collective work for both groups. So, while the trigger topics represented shared and salient dimensions of the participants’ trust experiences, they did not constrain analysis. They provided a relevant focus for the participants’ work at the time, but led into themes that were woven throughout the work, developed across individual narratives and sessions.

Before detailing the trust themes in the following chapters, it is important to point out that the women and men did not live the themes as disparate and isolated elements in their trust experiences. Separating these into separate threads and then extracting them from the fabric of the participants’ experiences is therefore artificial to a large extent. It will become apparent throughout the next chapters that the themes were interrelated, interlocked to the point where a single vivid example of text could

contain more than one example of different experiential aspects to trust. Therefore, at times, I have chosen to use long excerpts from individual narratives and group work.

As phenomenological texts, these quotes contain the meaning of trust for these participants, and offer us both cognitive meaning and non-cognitive meaning.

Cognitive meaning enables us to understand the informational and conceptual aspects of the experience, while non-cognitive meaning is grasped more from ‘between the lines’ of the text, and relates to the expressive, transcendent elements of the trust that participants experienced. Both meanings are necessary for a deep understanding of trust, in the phenomenological sense of *verstehen* (Patton, 2002; Schwandt, 2000).

So, in order to be true both to the participants’ experience of trust and to the epistemological foundations of Memory Work, the next two chapters do contain some long extracts from the participants’ work, as well as shorter excerpts. However, the sections and sub-sections detailing the themes tend to become shorter and contain fewer long extracts as the participants’ experiences build up, layer upon layer, our understanding of the interconnectedness and wholeness of the trust phenomenon.

Throughout the following chapters I include full reference details for the participants’ quotes so that they can be found easily in the transcripts (included on CD with the thesis). The reference details in parentheses at the end of each quote generally include the name of the participant, a notation that identifies the session the quote is taken from (e.g., ‘W#3’ indicates Women’s number 3 session), and a numeral that denotes the line number in the transcript where the extract can be found. When it is important to understand that the passage occurred in the context of group work, this is indicated as ‘Collective’ within the parentheses.

5.4 Ethical Considerations

This research was conducted toward the end of 2001, part of a time period when the public was becoming more aware of the shortcomings of the health care system in New Zealand, and as a consequence, generally more cautious and cynical about the health care product they were being offered (refer to Section 2.3 The New Zealand Health Care Context, in Chapter 2). Because of the sensitive nature of the research topic (both personally and politically) there were several important ethical issues to be considered and accounted for in the research design.

Anonymity

To ensure anonymity of the patients and of the primary health care practitioners, participants used a pseudonym for themselves, as well as pseudonyms for the practitioner and any other people mentioned in the narrative. Participants also changed any street names, the names of suburbs, towns, or cities by which people or health care practices might be identified. When I was aware that a participant had slipped back to using real names in a narrative, I changed these to pseudonyms before the individual narrative was published in the booklet containing all of the narratives for discussion for the next session. If participants reverted to real names during group discussion, generally they were reminded by another participant to use fictitious names, and I substituted the pseudonyms in the written transcript of the discussion. This use of pseudonyms protected the participants, the practitioners, and finally, the university itself from any legal challenges.

At a much more personal level, the use of pseudonyms is one of the techniques employed by Memory Work to protect participants from the potential risk in the method to be disruptive and destabilising for participants (for a full discussion of this effect see 'Destabilisation' in the section entitled Some Issues, in the previous chapter). Thanks to a destabilising experience I had had as a participant in a Memory Work session on gender and materialism, when I found myself (quite unexpectedly) confronting intense emotions around domestic violence, I was particularly sensitive to the safety issues for participants in this study.

Confidentiality

The need for confidentiality was also stressed, in the research information booklet, during the personal meeting with each volunteer, and throughout the research process. Participants agreed formally to protect the confidentiality of the other people involved when they signed the research consent form. They were also given the right to request that certain information remain confidential to the group and not be used in the reporting of the research (Research Information Booklet, Appendix D).

Personal Safety

Initially, I decided to access only staff and students of the University of Waikato so that we could access (free of charge) the counseling services available on campus, should a participant need to continue discussion with a counselor. (In the end, two males who worked off campus became participants on the condition that they take responsibility for arranging counseling services themselves, if they needed to.) See Consent Forms, Appendices H and I respectively.

I discussed the possibility that participants might find the memories upsetting, both in the Research Information Booklet (Appendix D), and in discussion with participants individually and as a group. I asked participants to think about the personal support networks they would use in case they found that they needed to talk about their experiences with friends or family. In the research information booklet I also provided full contact details for the campus counselors, my supervisors, and myself so they could contact us easily. I explained in the booklet that the group process of Memory Work provides opportunities to work through any possible painful memories to a satisfactory outcome; I detailed these techniques in the group briefing and regularly throughout the course of the group sessions.

Finally, I designed formal debriefing times (at the beginning and end of each session) into the method for these groups, and made a point of telling participants that these debriefings would be a standard feature of the method. These debriefing times enabled participants to talk about anything that had come up for them as they were writing about their experiences, or in discussion as part of the group; and they provided the

group with the opportunity to support any member who needed extra discussion or reassurance to understand a particular experience. From time to time I also contacted participants individually (face-to-face, email, or telephone) to check if they were having any difficulties with the method.

My overall aim was to design a safety net that would ensure that the research process would honour the courage and dignity of the men and women who would be disclosing the intimate details of their health care experiences. Later, I came to realise that one of the paybacks for ensuring the participants' safety is richer and more fulsome data: when participants feel safe they trust, and their disclosure is fuller. I became increasingly aware, as the research proceeded, of the huge contribution the participants were making toward this research and felt very keenly a moral obligation that the research process respect the rights, needs, and values of these men and women.

- *In My Own Words. Men's Group Briefing:...must remember to honour their time, and commitment. Remember that while the sessions are being held in my home, they are professional sessions, not casual chat sessions. Watch/strive to create a balance between comfort/casualness for the participants and respect for what they are doing – their "work" which is taking place in an informal environment but which is no less valuable because of that fact.*
- *Men's Session 1: One of the men's narrative very intense. Felt quite scared at how intense and personal it was. Involved being taken advantage of sexually. Found the best way was to remind myself that I was in a position of trust, and to be humble in the face of it, trust that it was all meant to be. Concentrate on*

honouring the men, respecting them and their trust, their narratives. Dave has told one other person about this incident – a female partner, about one year afterwards. This is a great demonstration of good faith, trust.

Standard Ethical Procedures

Apart from these specific ethical considerations relating to the nature of the topic, the research honored the standard ethical principles for human science research (Creswell, 1994; Moustakas, 1994). After a rigorous examination period spanning several months, the research was approved by the Ethics Committee of the Waikato Management School at the University of Waikato. The nature, purpose, and requirements of the research were established clearly both verbally and in writing (see Appendix D), so participants understood them fully; participants gave their written consent to participate in the research (Appendices H and I); participants were given an assurance (written and verbal) that they were free to withdraw completely from the research project, or to withdraw certain information only, at any time (see Appendices D, H, and I); participants were given access to all verbatim transcriptions and written interpretations (Appendix D); participants were continually assured throughout the course of the research that they could adapt the method as needed for safety and comfort.

Participants understood that the research was financially independent and that it was not sponsored in any way that would compromise its research merit or ethical acceptability. Research expenses were covered by a Merit Study Award granted by the Waikato Branch of the New Zealand Federation of University Women, a

University of Waikato doctoral scholarship, and the Department of Marketing and International Management. I also made it clear to volunteers that while they would not receive any monetary reimbursement for their participation they could expect social and personal benefits from taking part (see Research Information Booklet, Appendix D).

5.5 Advantages and Limitations of Memory Work

Advantages

Memory Work bears some similarity to other qualitative methods, notably those based on account collection and analysis (e.g., critical incident method), and case history methods. All deal with meaning and interpretation, share an epistemological basis in treating the subject and object of knowledge as “correlative and co-constitutive” (Kippax, 1999, p. 93), and emphasise the shared nature of meaning.

Memory Work, however, focuses on memories rather than events. Herein lies the fundamental difference between this method and others. While a memory refers to some real event in time, Memory Work acknowledges that the memory is a construction of the event, a construction that changes over time with reflection. The method is concerned with the construction itself, because “the construction tells us something about the way the person relates to the social” (Crawford et al., 1997, p. 8). Thus, Memory Work offers the researcher the opportunity to understand deeply the social processes involved in the meaning that participants make individually of events

in their lives. In this way too, Memory Work is also focussed on deconstructing the participants' constructions of self (Crawford et al., 1997; Haug and Others, 1987). These features of Memory Work suggested that the method would facilitate deeper insights to the interaction of trust and the social processes of gender than methods based on accounts or case histories.

The collective discussion, interpretation, and theorising by Memory Work participants also set this method apart from other qualitative inquiry methods. During this group process the shared elements of their experiences become evident, and it is the participants themselves, together, who construct the common sense understanding of the phenomenon of interest. These collective processes also give the participants the opportunity to see how they have constructed themselves, in a way that other methods cannot, a characteristic of Memory Work that gives the method the potential to be empowering for those taking part. These and other advantageous features of Memory Work have been discussed in more depth earlier in this chapter and the preceding chapter.

Limitations

Memory Work shares some of the recognised limitations of other qualitative inquiry methods, notably those methods that occur in a group setting. Group norms that emerge as the research progresses are likely to influence both the writing of the narratives and the collective discussion, as participants determine what is expected and appropriate within the group context. As in any group, certain individuals can tend to dominate the group process, (despite conscious attempts to set up Memory

Work groups as collectives). This means that rather than five views being represented, at times only two or three sets of views might be reflected in the data. Because the groups are initiated as a research project, the initiator can often be expected to assume a leadership role; in Memory Work such an expectation compromises both the intention that all members are of equal status, and the collective processes of the method. The presence of one person as ‘researcher’ can also bias members’ responses (Creswell, 1994; Fontana & Frey, 2000; Grbich, 1999; Schratz-Hadwig, 1995; Willig, 2001).

Other limitations relate to narratives. Researchers are aware that narratives are shaped by the intended audience, as determined by the author (Clandinin & Connelly, 1994; Manning & Cullum-Swan, 1994; Richardson, 1994). Thus, the same material can be written differently for different audiences, crafted according to whom it is that the author wants to reach, and the author’s subsequent ‘goals’ for writing the narrative. The form, detail, plot, tone, and language of the narrative could be influenced by whether the author conceptualised his/her audience as the researcher, or other participants, or readers of the thesis, conference proceedings or academic/professional journals.

- *In My Own Words. Editing: After lunch with R. have realised that it is probable that participants edit their stories – to control the amount and nature of information that is given to the others, to ‘manipulate’ discussion (so topics of personal interest or topics which haven’t been discussed yet are discussed), or, as R. said today, to give me what they think I want or need as a PhD researcher.*

In practice, we found that the group processes of Memory Work seemed to work to reduce the impact of method limitations such as those discussed above. Somehow, because we were members of a group, each of us was directly ‘answerable’ to several co-researchers rather than working with one researcher only. At this level then, the group of this method perhaps was more able to guarantee the authenticity of participants’ work than research methods based on dyadic interactions between a sole researcher and a sole participant.

As more qualitative researchers choose Memory Work as their method of inquiry, and apply it in more research domains, we learn more also about its methodological limitations and advantages. The quality of the data depends to a large measure on the ability of participants to articulate, deconstruct, and theorise their experiences. Not all the members of the group are going to be equally articulate, perceptive, or able to contribute to the collective analysis and theorising. In this research, when I noticed that an individual was not involved in group discussion, then I generally asked directly for their input. At various times other group members also deliberately opened up space in the group forum for a participant who had gone quiet. At other times, it was inappropriate to do this because an individual was reflecting, or engaged in listening but not talking. Finally, over the course of the research we routinely revised aspects of the method itself, going over the guidelines for specific individual and group tasks, and emphasizing the importance of the method’s collective processes and dynamics.

Other researchers note that the composition of the group affects the data produced. For example, some researchers have chosen to use groups comprising academic

colleagues (e.g., Crawford et al., 1990; Haug & Others, 1987) or friends (e.g., Kippax, 1990; Koutroulis, 1993, 1996) on the ground that such bonds facilitate the reciprocity and trust necessary for honest, deep disclosure. Other researchers suggest that friendship bonds can sometimes have an adverse effect on the research process (e.g., Schratz-Hadwich, 1995). In this research, none of the male participants had met one another before the group met, although I knew one of them as a colleague and a friend. The women's group was a mixture – three of us knew one another while the remaining two women were newcomers. In my experience, these bonds did seem to provide a ready-made base for establishing rapport and cohesion between the participants of each group as a whole.

However, on reflection, these friendship bonds would have contributed to the difficulties I had finding a healthy balance between the roles I perceived I was juggling in the research context – friend, participant, facilitator, co-researcher, researcher. Moreover, these bonds might also account for the apparent difference in focus between the two groups – the men's group appeared able to sustain a steady focus on the research purpose, whereas at times the women's group seemed happier to socialise than to do academic-type analysing or theorising. I agree with Schratz-Hadwich (1995) that one of the big challenges in Memory Work practice is developing – and maintaining – the right balance between serious intent and conviviality within the research group.

5.6 Concluding Comments

Memory Work was especially appropriate for this inquiry because of its history of application in gender research. The method was developed specifically to explore a

gender issue; namely, women's gender socialisation and its relation to the process of sexualisation of the female body. Since then scholars have used the method for research into various feminist and gender topics, including gender in the marketplace; for example, the student consumption of leisure activities (Friend & Grant, 2001), and consumer satisfaction and dissatisfaction in retail exchanges (FitzPatrick, Friend & Costley, 2001; Friend, 1997; Friend & Rummel, 1995).

Both male and female patients can be seen as comprising marginalised groups in a discourse context in which power is both appropriated by and relinquished to the practitioners. Because it was designed to give voice to a specific social group (women) at a time when their realities were typically neither seen nor heard, Memory Work seemed the ideal way for this research to 'hear' the trust experiences of male and female consumers whose perspective is seldom invited. Moreover, its focus on socialisation processes makes Memory Work ideal for understanding gender as one aspect in patients' socialisation as health care consumers.

Memory Work's historical basis remains relevant. The method's creators viewed gender as a process whereby women and men, "as subjects within culture, are 'made'" (Haug & Others, 1987, p. 14). They saw gender as a process that is constantly evolving for individuals who, as active agents acquiesce in the social relations of their situations, but also unconsciously participate in the construction of gender as a social structure (op. cit.). Clearly, this is in line with current conceptions of gender. Memory Work's acceptance of gender as a process suited it well to this research.

The notion of gender relationality, that we live out our masculinity and femininity relative to others of the same gender and to others of different gender, is one of the important tenets of feminist ideals and practices within gender research (Brabeck, 1996; Lykes, 1994; Penaloza, 1994). The Memory Work framework leads us to identify differences between individual experiences and also to find the shared gender patterns and processes that link those experiences. Moreover, its focus on both the differences and similarities within and between genders allows this research to conduct a comparative study of gender and trust as a relational phenomenon.

In summary, Memory Work seemed the method that would best enable a deep exploration of patients' gendered experiences of trust as a socialised dimension of the relationship between them and their primary health care service providers. The following two chapters present the themes and theorising of the groups. Chapter 6 presents the women's experience of the trust phenomenon and their understanding of those experiences. Chapter 7 re-presents the men's trust experiences and their subsequent theorising that accounts for the ways in which they have made sense of their trust in primary health care practitioners. In Chapter 8 I interpret the groups' work and establish links from their data to existing bodies of academic knowledge.

6: The Women's Experiences of Trust

*“My GP would know what to do...he would fix it...he would deal with it...
whatever needed to be done” (Jane, W# 4:1476).*

6.1 Introduction

This chapter presents the work of the women's group on their experiences of trust in their primary health care practitioners (PHCPs) and their ways of making sense of that trust. The chapter focuses on the women's own descriptions of the phenomenon of trust in the primary health care context and the interpretive themes that emerged in their construction of those trust experiences. Just as the participants kept coming back to certain topics as they articulated their understandings of trust, so these recurring themes will be woven throughout the remaining chapters.

This chapter begins the process of answering the research questions around which the project has developed. The phenomenological nature of the central research question, “How do male and female patients describe and perceive their experiences (both positive and negative) of trust in primary health care practitioners?” and the subquestions (refer Section 1.3, Chapter 1) provided the blueprint for this chapter.

In this chapter I seek both to describe and to explain the women's trust experiences. The chapter describes individual experiences of trust with PHCPs, and layers these with the reflections and understandings that the collective developed to make sense, or

meaning, of their experiences. It also begins to weave together with the women's voices my interpretive extension of their experiences, and understanding from academic researchers and theorists. This interweaving, one narrative with another, narrative with interpretation, women's interpretation with academic, continues the hermeneutic rhythm established by the women in the collective data analysis during the Memory Work sessions. It enables us to examine the commonalities and differences in the participants' experiences, to build our understanding of them, and to uncover the meaning in their construction.

The Women's Ways of Telling 'Trust'

It is important that several general points be made about the women's work before exploring it in detail. The women expressed their experiences and meanings of 'trust' in an interesting range of ways. Together, these ways of telling trust create a backdrop that enriches our understanding of how they lived trust in PHCPs and why they used particular constructions to make sense of their experiences. The range itself points to the subtlety and complexity of the trust phenomenon for these participants. Telling 'trust' was not a simple, straightforward task.

Trust in a PHCP, for these women, was often a highly charged, emotional experience. They detailed a range of emotions, experienced at different levels of intensity, as they explored their relationships. The emotion was evident in the language they used, heard in their voices as they spoke, and at times was so strong that it prevented the woman from speaking at all. This affective dimension to their trust ran as a current throughout the research.

It appears that trust can also be lived as a very intimate experience. These women frequently referred to their closest personal relationships in the telling of their trust in PHCPs. Parallel to their PHCP narratives, they ran stories about their personal relationships with family, friends, and life-partners. This use of their most intimate relationships as points of reference gives us another indication of the intensity and depth that can characterise the professional relationships these women have with health care providers.

Finally, in their discussions the women often juxtaposed positive experiences of trust and negative. Relating their negative experiences helped them to express by comparison the subtle nuances of the positive, and helps us to grasp the finer contours of an individual's trust constructions. Participants had been invited at the outset of the research to explore their negative experiences of trust as well as their positive.

Because I had intellectualised positive and negative experiences of trust into two discrete phenomena as I prepared for the research process, I had expected that they, similarly, would explore these as two neat, clean, quite separate parts of the research.

This is not the way these women presented their experiences. Certainly at times they did focus on either a particular positive or negative experience. But frequently they constructed the meaning of positive experiences relative to their negative experiences, and vice versa, moving naturally between the two. Communicating 'trust' involved a process of comparing their experiences – a new experience with their past experiences, the positive with the negative, one woman's with another's. Therefore,

following the lead of these women, discussion of the themes of their trust will incorporate details of both positive and negative experiences.

6.2 The Relational Heuristic Device

On reflection, I can see that from the outset of this research I had been interested in understanding the trust phenomenon in chunks, named 'affective', 'cognitive', and 'conative' after the work of Doney and Cannon (1997) into trust in buyer-seller relationships. Accordingly, I designed research questions that would guide our study of trust along these lines, and reminded participants at the briefing for every session that these were the areas of the experience that we were interested in understanding.

The women did not experience trust in these particular chunks. They certainly experienced affect, cognition, and some physiological and behavioural dimensions in their trust, but they did not naturally 'chunk' it into these separate dimensions in their narratives or discussions. Moreover, apart from teaching me some sobering lessons about the nature of qualitative research, this unexpected turn of events made the affective-cognitive-conative framework redundant also as the framework for deconstructing their trust experiences, and for my re-appraisal and extension of the women's work.

For these women, trust in their primary health care practitioners was a dynamic, multi-faceted, complex experience, frequently lived as a very rich and vivid phenomenon in their relationships with these providers. Because it was both artificial and unproductive to dissect these experiences into disparate segments, I use the

concept of 'relationship' as the base for a heuristic device to present the participants' narratives and analysis. This framework emerged out of the women's data - once I had given up the battle to fit the data into the boxes I had brought unwittingly to the research. The relational framework and heuristic device grew quite simply out of very deliberate reflection on how the women themselves had understood their trust experiences. The development and practical application of the relational heuristic constitutes one of the major contributions of this research (see Chapter 9: Conclusions and Contributions). I use the heuristic for organising the women's and the men's data in this and the next chapter, and in my extension of their work in Chapter 8. The relational heuristic device is detailed here.

Trust does not occur in isolation (Jones & George, 1998; Lewicki, McAllister, & Bies, 1998); rather it occurs when a person is in-relation with someone or something else. In other words, trust can occur only within a relationship. It requires both an I and an Other. Sometimes the Other is Another person, sometimes it is Myself. At other times, the Other is inanimate, e.g., a piece of equipment, a particular hospital, or the medical profession in general. Trust as a relational phenomenon thus has both individual and social qualities; an individual's experience of trust simultaneously has what Dewey coins the "internal" and the "existential" conditions of any experience (as cited in Clandinin and Connelly, 1994, p. 416). Because this research is concerned with the perspective of the patient on trust, in this experience the individual patient is the 'She' (or 'He') and the PHCP is the 'Other'.

In the process of trying to understand and make sense of these trust experiences we need also to consider the relationship itself. According to the central principle of

Gestalt psychology the relationship, or the whole, is different and/or greater from the sum of the individuals, or the parts of the whole (Colman, 2001). The relationship itself has its own dynamics and a synergy that is different from the sum of the I and the Other; the whole has a synergy created in the intersection of its internal and existential conditions. In this research, the patient and PHCP together create the relationship of 'They'.

This relational framework is embedded in the women's data. They commonly described and understood trust according to how it related to themselves as individual patients, how they perceived it relative to the PHCP, and finally, they made sense of trust as a characteristic or property of the relationship as a whole. I did not have to fight any body or any data to use this relational framework constructively. My re-appraisal and extension of the women's data respects their work as the experts in the phenomenon of trust. In this way the interpretive analysis (theirs and mine) is not separated from their personal storytelling and sense-making; rather it completes the hermeneutic circle of understanding within which we are connected by a common purpose.

Furthermore, the framework is consistent with the social constructionist precept that we co-create meaning in our lives. This precept is one of the epistemological foundations on which the Memory Work method is built. For these reasons then, the 'She'/'He'-'PHCP'-'They' heuristic was appropriate, natural, and productive to use in the re-appraisal and extension of this data. Elements of the heuristic can be found in Buber's I-It/Thou philosophy of being in relation to others (1958), and also in the She, He, and We scheme of relationships developed by Johnson (1983) from the work of

psychologist Carl Jung. There is additional theoretical support for the separate components of this heuristic in the work of Arantola (2002), Denize, Young, and Miller (2000), Doney and Cannon (1997), and Kumar, Scheer, and Steenkamp (1995).

The rest of this chapter focuses on detailing the women's experiences of their trust in PHCPs. The descriptions of trust and the themes to their constructions are presented solely from the perspectives of the women. The themes are based on the central perceptions and understandings that the women themselves used to make sense of various dimensions of their health care relationships as facets of the trust phenomenon. They are common sense-making themes for trust that occurred across a range of different primary health care encounters (encompassing, for example, different health modalities, different providers, different health conditions). It must be noted that within each theme there were also differences in the ways a single individual experienced it in her various interactions with practitioners, as well as differences in the ways she used the theme to help her to articulate and construct her trust.

6.3 The Female Patient as 'She'

The women's perceptions, descriptions, and understandings of trust can be easily grasped when we understand them as they relate to the relationship itself that the patient has with the health care practitioner. In the relational heuristic, 'She' refers to the domain of the individual female patient, and the internal individual aspects of her trust experiences. These are the aspects that are felt and/or focussed mostly on the patient herself, which originate from the Self, are directed toward the Self, owned or

claimed by the Self. There are four themes to the women's understanding of their experiences of trust at this level: Vulnerability, Knowledge, Affirmation, and Voice.

Theme 1: Vulnerability

Vulnerability is a prominent theme in the women's experiences of trust. Its importance is reflected in the women's decision to devote an entire session to the theme, using the trigger topic "Being vulnerable". For these women vulnerability was a necessary condition of being a patient: *"It's being in the health care situation that creates the vulnerability"* (Melissa, W#3: 2831). This sense of vulnerability could be felt quite keenly even before their encounter with the primary health care practitioner – these participants understood that the very fact they needed health care put them automatically in a position of vulnerability. However, their deep descriptions of vulnerability as it related to trust centred on their actual interactions with PHCPs.

Forms

Their individual narratives described vulnerability in the language, feelings, and actions of the women living Vulnerability with a PHCP. The narratives detailed a range of Vulnerability experiences, shaped and made meaningful by the individuals who were interacting within the woman's health care context. Thus, in the context of their encounters with providers, 'vulnerability' took several different forms, as the women recognised part way through the session:

Louise: For me it [vulnerability] was being alone.

Jane: For me it was being scared...worrying for someone else though. Not for me so much, but being worried for my children.

Melissa: To me it's betrayal.

Amy: To me it's everything you've all just said...

Emma: And I also think for my part it was a lack of knowledge as well. (W#3:2031)

The following excerpts from their narratives illustrate in more richness some of the women's variations on Vulnerability. In an incident in which Melissa had to wait in an accident and emergency clinic with one of her sons who had suspected concussion, she experienced vulnerability relative to her sense of personal power and control. This sense was threatened by simply being in the position of 'patient'. Deeper insights to this form of vulnerability came from her narrative:

What did Melissa know about being vulnerable? She was never vulnerable. And even if her protective barrier slipped on occasion she was never going to let anybody else know about it. Vulnerable equated in her mind with weakness and if there was one thing in her life that she didn't have time for it was weakness...

Melissa as she always does at these times remained totally calm and directed all the necessary events...

Nothing to do but sit and hold her son's hand while his condition continued to deteriorate. Melissa tried to remain in control but she could feel her composure slipping away. She was beginning to feel that enemy sneaking up on her. She could do nothing... (W#3:146)

In this instance, the vulnerability-as-'betrayal' that Melissa referred to in the collective discussion can be understood to be a betrayal of herself. In an extract used in the following sub-section of this same theme, Melissa explained that she felt also that her vulnerability in this situation was a betrayal of her son in his vulnerability. She illustrated another form of vulnerability in the narrative detailing her husband's

betrayal of her during the birth of one of their children (see sub-section 'Fear' of this theme).

Emma's vulnerability occurred around her lack of knowledge. She did not know what the 'routine' was for a cervical smear, what the procedure entailed, or what was likely to happen to her as the patient. Because this was Emma's first smear, she had no previous experience. Her mother had told Emma about her own cervical smears and Emma had listened to friends talk about theirs, but they had not given her any details about the procedure. Finally, once she was at the clinic neither the nurse nor her GP explained smear-taking to her. She went through the entire procedure not knowing what to expect, what would happen to her, what the doctor was going to do, what she would be required to do as the patient, what instruments would be used, and what she might experience physically as the result of the smear:

Dr Fritzbaum came out of his rooms, then took her file from the receptionist and called Emma's name...He asked her what he could do for her. Emma was a bit surprised. "I've booked a cervical smear test," she said. He looked a bit muddled, and then embarrassed, a reaction she hadn't expected. From that point on he seemed very nervous. Emma felt uncomfortable.

Dr Fritzbaum didn't waste any time, or go into specifics about what to expect. He told Emma to lie down on the bed, and he pulled the curtain around to maintain some privacy. He asked her to remove her underwear. She heard him washing his hands which she felt relief at, but she thought maybe he should be wearing some gloves. He didn't appear to be though.

He came alongside the bed and instructed her to bend her legs, and spread them apart. He had a metal contraption in his hand. She thought to herself "My God, what on earth is that?" Dr Fritzbaum then said, "You're going to feel a bit of discomfort. I have to use this to gain entry to the cervix and then use this long cotton bud to take a swab. Try not to move too much."

Now Emma was really worried. He inserted the metal contraption. "Yooouch," she thought. "That really hurts...I'm sure he's not doing this right!"

He seemed to be very uncomfortable with the whole experience as well. She glanced at his face. He inserted the long cotton bud to take a swab. "Right," he said, "That's done." He smeared the swab on to a piece of glass and enclosed it in a plastic bag. He removed the metal contraption, and asked Emma to close her legs, and he left the cubicle while she put her underwear back on.

While she was doing this she noticed some blood on the paper sheet laid on top of the bed. He hadn't mentioned anything about that. Dr Fritzbaum was muttering something about sending her results to the lab for testing. "You'll receive notification in the mail and be placed on the cervical screening register which means you'll have to have a smear test every three years."

Emma didn't ask Dr Fritzbaum about the bleeding. She was too embarrassed. Dr Fritzbaum seemed as though he couldn't wait to get her out of the way. "Right, that's fine," he said. Emma thanked him and left. (W#3:659)

In this narrative Emma's emotions ranged from an initial hesitancy through embarrassment to indignation at the GP's behaviour, and anger at herself for acquiescing in his management of their interaction at the expense of her self-respect. Cognitively she went from surprise at the GP's apparent lack of preparation to doubts about his competence. The women discussed Emma's silence throughout the procedure and understood it as a common female response, a learned response both to authority and to pain.

Authority and pain were both important factors in Emma's smear-taking, and indeed featured in many of the women's primary health care experiences.

Jane's narrative, for instance, revealed different 'types' of pain that were experienced in her vulnerability:

Jane was right to be scared and worried – she was vulnerable to pain of several types [physical and emotional], particularly given that at the time Jane was still on two different antidepressants designed to help her get back on a mental track....Her physical problems at a time when she was already vulnerable were more than she could take. (W#3:2211)

Pain and authority were evident too in Louise's narrative, for instance, as part of her experience of Vulnerability, which centres on being left alone:

Louise is very scared. She does not want the pain. She does not want to go the distance. It's too long. Hours and hours of pain. Pain that totally takes over. Engulfing who she is and leaving her mentally stunned. Physically exhausted and a wrecked body shell that is not hers. She does not want to be doing this. She is not ready. She does not want to be here.

The room is large and colourless. The bed is up against one of the inside walls with a large piece of monitoring equipment on a trolley to the left of her, less room and smaller equipment to her right - an oxygen tank maybe. There is room on both sides of her for nurses to get in and up close. There are big lights above and odd trolleys and bits of equipment around the edges of the room. The ceiling is acoustic tiles. On the wall behind the bed is the switch for the gas. The bed is lighted, around the room is darker. It is evening.

As the contractions roll in Louise and her body remember the intensity of the pain and resist its pull into the huge, dark place where she is always alone. There are two nurses coming and going about her. Talking to her and telling her what to do. She tries to make some sort of personal contact with them - a comment made with deliberate eye contact. But they are busy and efficient. Matter of fact. Taking turns to tell her "You can do it" and "It'll soon be over". But she knows the Black Place well, and doesn't take any reassurance from their token soothers.

They work to get things ready for the GP who is expected any time now. She is measured, tidied and quietened. Andrew arrives. Her GP. An attractive man, of her own age, well-dressed, with a beard. He comes up to her, smiles and asks how she is going. "Fine," Louise replies. Now she can be brave. He moves toward the bottom of the bed as the nurses

fill in him with the ever-important measurements of cervix and time. Louise watches and listens.

Suddenly Matt is there and the two men come back to the bedside and talk to her. They stay with her through a contraction and then move off toward the end of the bed. They talk the birth talk of male health care practitioners, impersonal talk full of medical terms and shared knowledge. Louise is left out of it. The talk moves on from birth to health care practice, and eventually, both leaning up against the back wall in the shadows, to real estate prices in Stanmore Bay, the suburb where Andrew has recently purchased a house.

Louise is alone again, the nurses come and go as she is washed into more contractions. She starts to lose it. "Time for the gas," she is told by one of the two nurses. Andrew goes home for some dinner and a rest. (W#3:1208)

Amy's narrative of Vulnerability is similar to Louise's in its focus on being left alone.

Amy's text was built around her perception that she had been 'abandoned' in the health care situation by her support people – her mother and her sister:

Amy was the fourth girl in the family and as such was used to being dragged along to her sisters' activities and doctor's visits, etc. This time they were off to the dentist. At six years old Amy had never been to a dentist herself. She still had all her baby teeth but was aware that they would fall out (she eagerly awaited the tooth fairy) and she would get big teeth like her sisters.

The dentist's office was in a neighbouring village. Mom parallel-parked along the pretty, tree-lined street and all four girls tumbled out of the car. The building was two stories and at one time probably had been a residential townhouse but had now been converted to a dentist office.

The bottom floor was the waiting room. Upon walking into the room, Amy noticed the fish tank filled with lots of pretty fish swimming about. She enjoyed watching the fish dive and play hide and seek among the plastic coral and rocks. A corner of the room was the kids' area containing a round table, some chairs, books and toys. "This isn't too bad for a waiting room," thought Amy. She had been in some that were really quite boring.

Her sisters were eventually called "upstairs" where the examining rooms were located. Mom stayed downstairs with Amy. Amy proceeded to play in the kids' area with some other children. Then Mum called Amy to come upstairs with her. Amy thought they were going to collect her sisters but Mom took Amy into an examining room to meet the dentist.

The examining room was white with a big reclining chair in the middle of it and some strange, weird lights over the chair. The dentist sat on a swivel chair. All of a sudden, Amy felt like she had been yanked from the safe, secure world of the kids' play area and propelled into an alien planet. Mom and the dentist were telling her that the dentist wanted to look at her teeth and to climb into the chair.

"NO WAY," (thought Amy.) She tried to beat a hasty retreat from the room but Mom blocked her way. The dentist hoisted her up in to the chair. "Let me go," she yelled, "You aren't looking in my mouth." Who the heck was this guy, thinking he could poke around in her mouth and shine that awful light in her eyes? Amy tried kicking him and pushing him away but wasn't able to. "I don't know you, I don't trust you, I'm not even sure what you are planning to do in my mouth and why," she thought.

"So if kicking doesn't work, let's try a different strategy." Amy relented just a little. Enough for the dentist to stick his fingers in her mouth. "So do you want to see what kind of teeth I have? Well, I'll show you". So she bit his finger. The dentist was not at all amused. Amy had her mother leaning over her telling her to be nice. That all he wanted to do was look in her mouth.

"Where is my sister Sally? She was my support person. She would rescue me from this guy," Amy thought. Amy was getting madder by the minute and if it had been possible to bolt out of the chair she would have. She finally decided to ease up on the dentist. "Maybe if I let him have his look I can get this over with," she thought. Thankfully, the dentist had his look, then leaned back in his chair and let Amy escape from him. Amy could hear him telling her mother that he thought Amy might need braces in time and that she should see the orthodontist who was in an office across the street.

Somehow Amy got into the car with the keys to the car. (Either she asked Mom for the keys or else the keys were already in the car. This is the 1960's and people still left their keys in the car! This was a very small village.) Anyhow, Amy climbed into the car and before anyone else could get in she quickly locked all the doors. Now she was in the car (with the keys) and

Mom and sisters were standing outside of the car. "Safe at last," she thought. (W#3:2621)

Like Emma, Amy's vulnerability also involved lack of knowledge in the sense that she was totally unprepared for what was going to happen to her.

Perceived Risk

The women's stories and discussion converged on the notion of risk. This was not unexpected. Characteristically the narratives triggered in Memory Work are subjectively significant in some way, often problematic and/or unfamiliar (see 'Memories' in Section 4.7, Chapter 4). In this research then, individual narratives were likely to concern trust experiences that had taken place in complex, more involving or more consequential health care circumstances than in simple, straightforward encounters with practitioners. The former health care circumstances are generally perceived by patients to be high risk, and risk is inherent in a patient's vulnerability (Gabbott & Hogg, 1998). All of the 23 memory texts written by the women participants involved health care contexts that can be understood to be complex (refer to Marketing Implications in Context, Section 2.5, Chapter 2 for characteristics of complex service contexts), and subsequently perceived by them as high risk situations.

In the previous extracts, the vulnerability they experienced in these risky situations left each of these women open to hurt of some sort. In the health care context this potential harm can be physical, emotional, spiritual, and/or social, and can be inflicted by the PHCP and/or any one of the other people involved in the situation. For

example, Jane's vulnerability had serious social implications and was shaped largely by her relationships with her children and husband:

She was worried about being sick because just the month before, her middle child had been in hospital which meant that her husband had had to take time off to look after the other two. Hopefully this was just a bug, and a jab with something would take care of it, as had happened before. It was not to be.

The doctor did a thorough examination and the outcome was that Jane had to go to hospital with appendicitis... Husband was trying to be supportive, and the doctor could not be definite - due to the late hour, it wasn't possible to do a blood test that would confirm the problem. Hospital was not something that Jane had a major problem with - she had been there with the children often enough in the last few years - but for her to go for a reason other than childbirth was very scary. She knew her husband wasn't happy about it either, although he was putting on a brave face, and that just made the situation worse for Jane.

The doctor was good but he was not prepared to let her go home without being seen by the emergency department at the hospital, given his diagnosis. So nervous, scared, and worried about home, children and how husband would react, if she had to stay in hospital, they went to the emergency department. (W#3:2196)

Likewise, Amy's vulnerability was framed by the actions of her mother, her sister(s), and the dentist – and continued to affect members of her family even after she had left the dentist's chair. Melissa, in the role of advocate for her son, felt her impending vulnerability as a powerlessness, both with herself and with the institutionalised health care delivery system they were in: “*We're always vulnerable where our children are concerned...In my story I was beginning to feel vulnerable...because I was feeling I was letting him down. I could do nothing*” (W#3:2031).

In her story Emma described actual physical hurt. Her hurt left spots of blood on the examination bed, ‘evidence’ of the physical damage that had occurred as part of her

encounter with this PHCP. (Interestingly, neither he nor she spoke about her blood – he had not warned her, she did not ask. This point will be discussed later in this chapter in the section ‘Silence’ in Theme 4: Voice.) Such physical hurt was merely one of the potential risks contained in vulnerability for these women.

Fear

More often, because of lack of experience, expertise, and specialised knowledge, the women lived the ‘hurt’ as an amorphous, insidious fear that, in some un-nameable way, their well-being could be adversely affected. And, always at the heart of these potential threats and dangers was an underlying awareness that, at worst, her life was at risk.

Sometimes this fear took the form, in a specific health care encounter, of an awareness that a person's physical well-being was at risk from a misdiagnosis. This was most apparent in Melissa's experiences. With years of experience as a trauma nurse she was well equipped with medical knowledge to evaluate diagnoses. She participated in most of her encounters with PHCPs acutely conscious of ‘exactly what could go wrong’ and the consequences for the patient of misdiagnosis or incorrect treatment.

Louise lived her vulnerability as a terror at the possibility of being left alone. Her husband and GP moved away from her bed to chat together at the back of the room – she was left both physically and emotionally. Likewise, the people Amy had thought she could rely on to help her out of the dentist's rooms were not there for her. Her

mother was not available - she had taken sides with the dentist. And her sister Sally, the rescuer, was not there physically. Both Louise and Amy were hurt at a very deep inner level. Because both women had been relatively powerless at the time in comparison to the other people involved – Louise because she was in the middle of giving birth and Amy because she was a young child – they were therefore particularly susceptible to harm. The experience of abandonment, which recurred throughout the women's work, reflected the patient's deep need for an advocate in certain health care situations.

For some of these female patients a particular experience of vulnerability was so intense that the woman consciously determined to change her behaviour so that she would not experience that same vulnerability again. Emma has become resolutely proactive in seeking out information herself about personal health matters so she can make informed health care decisions for herself, after finding herself acutely vulnerable several times because of lack of knowledge. Likewise, Melissa worked to become fiercely self-reliant and self-determining both as a patient and advocate for her children after her husband-advocate betrayed her trust and sided with the medical personnel in a military hospital. In this experience Melissa ended up giving birth in leather restraints so the birthing would follow standard birth procedure:

My first son was born in a military hospital in the States. I was quite young but even then I knew what I wanted and come hell or high water, it was going to be done my way. My soon to be ex-spouse was there and because I wouldn't comply the nurses drugged me and put me in four-point leather restraints...Over all my objections he stood there and let them do it.

I vowed and declared at that point I would never let anybody do that to me again. At that point it became Me. Because I was the only one I could rely on because the one person in my life who should have stopped it, shouldn't have even contemplated

letting anybody do that to me, stood back and not only let them, helped them.

When I, after the fact, I attacked him about it, I said "Why?" He said, "Well, they were officers." Because, of course, all medical personnel are officers and he was an enlisted man. "They were officers and I had to obey them."...

I said, "Screw you. You did not have to do it - because I'm not in the military." And ever since nobody is ever going to do that to me or any of my kids again. (W#3:217)

The women returned to the theme of vulnerability often during the course of their research. Other experiences of vulnerability were constructed on feelings of powerlessness and helplessness, being ignored or disbelieved, and not having her usual mental or emotional resources to make a considered decision for herself. The women's thick descriptions and deep understandings of vulnerability were based in negative experiences of trust. They had their fullest experiences of vulnerability in their negative experiences of trust. While the potential for such vulnerability is inherent in all health care relationships between patient and practitioner, trust reduces the likelihood that the potential will become a reality.

Theme 2: Knowledge

Knowledge is another aspect of trust that was experienced by the women in this research at a personal, individual level, and therefore fits within the 'She' domain of the relational heuristic.

In general terms, knowledge in this context relates to an individual's range of information, gained either practically from past experience or from another source as

an 'intellectual' understanding. A patient's lack of knowledge from past experience, and the fact that health knowledge is such a highly specialised body of knowledge, are major sources of perceived risk for the patient in any health care context.

Types of Knowledge

Within the health care context there are various types of knowledge. At different times throughout the research the women described 'knowledge' that related to

- particular health conditions: assessments, diagnoses, treatment and management, outcomes, consequences;
- health delivery: processes and systems, protocols, procedures;
- the people involved in the health care situation: the patient herself, her PHCP, other health professionals, and organisations (e.g., support networks); and
- the duties, roles, and obligations of others involved in health care (e.g., patient rights).

Amy's individual narrative about giving birth to her first daughter illustrated several of these knowledge types in a positive experience of trust with her midwife:

She hated hospitals, the smell, the starkness, the medical professionals, the machinery. So impersonal and cold, sterile. So when the midwife, knowing these feelings, agreed that Amy could try to have her baby at the birthing centre, Amy was thrilled. Even more so, after a visit to the centre. The birthing centre had the feel and look of a hotel. Wonderfully [presented and] garnished meals, attentive staff, nurses to teach you how to take care of baby. Amy even loved the little wooden bassinets for baby. They reminded her of the one she had for her dolls. "Perhaps giving birth, (especially here) won't be so bad after all."

Amy wasn't sure if it was a blessing or curse that one really couldn't anticipate or imagine what labour would be like. Talking to friends only helped slightly since everyone had a different experience. "Ignorance probably was bliss," she decided.

The midwife had reminded her that baby could only be born at the birthing centre if everything was OK. Otherwise it was off to the hospital. BUT, and this was an important BUT, if everything went smoothly at the hospital, then Amy would transfer to the birthing centre afterwards. "Sounds like a plan," she thought. Actually, one of the reasons for choosing this midwife was because several best friends had suggested her and had positive experiences and she was affiliated with the birthing centre.

Constance, the midwife, was a large lady, tall, with a slightly foreign accent and many years of experience. She was very businesslike in her manner, professional but still nice. She wasn't known for coddling her clients but she got the job done. As far as Amy was concerned, she wanted someone she could trust to bring baby into the world in a safe way and make smart decisions. Amy wasn't much into making decisions about the birthing process, just get it over and done with two caveats. One, try to avoid going to the hospital and two, try to avoid a C-section.

So, finally, there she was. Walking to and fro down the hallway of the house, knocking pictures off the wall and saying Hail Marys as she went. Actually she expected the pain to be worse. It was manageable. Hubby kept saying "We have to ring Constance - you're in labour." "How do you know?" Amy replied. "It could just be Braxton-Hicks contractions - it's not as bad as I expected. Besides, I don't want to bother her and wake her," Amy added. Hubby responded by saying: "You're in denial, like usual. I'm calling her."

First phone call. Constance said: "Hang in there and keep me posted."

Second phone call. Amy was now throwing up and feeling a lot worse than a few hours earlier although still had not accepted the fact that she was in labour. Hubby calls Constance who decides she will come right away.

Midwife arrives. Upon internal inspection, she declares that Amy is 10 centimetres. "Wow," thinks Amy. "How did I do that?" Amy was rather pleased with herself to have fully dilated without any drugs and being able to stay home. Hubby was ecstatic, jumping up and down.

Hubby then asks Constance, "Where do we go?"

"That's your choice," Constance replies.

Hubby: "Baby is still high. Do you think we'll need help?"

Hubby and Constance are having this conversation over Amy, who is still lying on the bed.

"Baby is still high and has not dropped, so yes, help may be needed. But you need to make the decision."

"Go to the hospital," Hubby declares.

Then he looks at Amy. "Are you OK with that? Remember, we need to be safe."

Amy agrees. On the one hand she knows that this is the right decision and she trusts Constance and her husband to make the best decision because she is in no mood or frame of mind to make any decisions. Leave the decision-making to someone else, she thinks. Emotionally, though, she is scared. With capital letters. "I don't like hospitals and I certainly don't like the one we are headed to – not after hearing so many unpleasant stories from friends."

However, off they go. Constance meets them in the delivery suits and starts attaching monitors to Amy. Amy is surprised that she is actually fairly relaxed. Perhaps it is knowing that she will soon meet the little person who has been kicking her insides for so many months. Or is it because Constance is clearly in charge? After several pushes and attempts at getting baby out, with no success, Constance calls for a doctor (registrar?). Katherine appears on the scene and appears concerned and agitated. "Baby is stressing," says Katherine.

"No, the monitor isn't working properly," replies Constance. Amy sees Constance leaning over her. Until now Amy has had her eyes closed, concentrating on pushing baby out. But baby keeps sliding back up. In a direct, commanding voice with a no-nonsense tone, Constance says: "Push Amy. One big push. Then we'll use the ventouse to pull baby out. Just one big push to get baby down. You can do this. I know you can."

Katherine adds: "If this doesn't work we'll have to go into theatre."

Amy closes her eyes, takes a big deep breath and goes for it. She feels baby being pushed down and before she can think, baby is being welcomed into the world. Then baby is rushed into the corridor for prepping and oxygen. Leaning back, exhausted, Amy asks, "Is it a boy or a girl?" then Constance wipes Amy's forehead, saying "You did well, really well and you have a beautiful baby girl. And since everything is OK you can go to the birthing centre." Relieved and happy, Amy turns to Constance: "Thank you." (Amy's narrative, W#1:p.23)

Amy's midwife Constance demonstrated experience-based knowledge, expert knowledge of birthing, knowledge of the hospital system, technical knowledge, and knowledge of Amy as a person. The central characters in this story also illustrate another key point about knowledge within a health care encounter: at any one time, the individuals in an encounter hold different amounts of knowledge. Thus, Amy had less knowledge about birthing than her midwife did; the doctor had less knowledge about the monitor than the midwife did. This is particularly important when knowledge is understood as a significant factor in determining the power balance within the patient-practitioner relationship.

Knowledge Dynamics

The women in this research needed different types of knowledge in different situations. At times they needed knowledge in the form of a diagnosis, at others they wanted information about a condition (e.g., Jane's urgent need for information about Bell's palsy after she had been diagnosed with it: "What the fuck is that?" W#4:904), treatment details, or information about the health care processes and procedures they would be involved in. Several of the women discussed incidents where they had required functional knowledge only – they did not want any more information other than clear directives on exactly what the practitioner needed them to do.

In their stories of positive experiences of trust, the women perceived that knowledge increased their control in the situation, enabled them to relax, reduced their fear, enhanced their pain tolerance, and minimised vulnerability. It is interesting to note that within such relationships of trust, these women constructed 'knowledge' in

slightly different ways, when they described it variously being shared, exchanged, volunteered, solicited, and/or generated.

In their negative trust narratives, the women explored instances when knowledge had been abused, withheld, or mismanaged (insensitively or inappropriately); at other times knowledge they brought to the encounter was ignored, contradicted, or dismissed. At these times the women felt disadvantaged on the basis of knowledge. The women lived this lack of knowledge variously as ignorance, doubt, fear, anger, powerlessness, an inability to prepare herself mentally during the incident, a compromised state of health and subsequent quality of life. Often, the women were aware that they were being controlled as a patient by the limited dissemination of the knowledge that was relevant to their personal health situation, and/or were conscious that they were in a state of ignorance.

Power

The women were unequivocal in their understanding of knowledge as power in these relationships. They returned to flesh out this understanding several times throughout their work together, and articulated this experience of knowledge very clearly:

Emma: ...if I feel I know as much as I possibly can then I've got more control over the situation.

Louise: See, this is a key thing isn't it? Control.

Melissa: Knowledge is power...

Amy: Yes.

Melissa: And power is control. (W#3:296)

Knowledge empowered these women at a deep individual level as human beings, as patients within a health service encounter, and as participants in a working

relationship with their practitioners. The women made a telling and direct link between knowledge and self-confidence – felt as confidence both in themselves personally and in their role as patients. Health-specific knowledge imparted by the PHCP as part of assessment-diagnosis was lived as extremely important. This type of knowledge reassured the women that her own knowledge of herself was sound and trustworthy, so that she was right and able to trust herself. It also reduced the fear of the unknown, and indeed, conveyed hope to the patient, insofar that once her condition had been named, the patient could move on and deal with it. Jane wrote about these common-senses in her narrative:

Dr Timms reassures Jane that she is actually sick, that there is something to be done about it to make her better, and that she is not becoming a hypochondriac and complaining about nothing. It is the beginning (to coin a phrase) of a beautiful relationship which continues to this day, with the same thoroughness whenever Jane goes to see him. (W#5:2535)

Conversely, their work indicated that lack of knowledge disempowered them as individuals, limited their choices and constrained them as patients, and compromised the development of their patient-practitioner interactions.

Within the parameters established by this understanding of knowledge as power, however, there were interesting differences in the amounts and types of knowledge that the women needed. These needs varied according to

- (1) individuals, their personal circumstances and trust experiences;
- (2) specific health situations; and
- (3) the nature of the relationship they had with their primary practitioner.

For example, Amy's lack of knowledge is critical in her memory of the traumatic childhood dental examination. In that situation she had no previous experience to draw on, she lacked knowledge about the process she was involved in and her role as patient, she had no personal knowledge of the dentist, and she was further confounded by confusion about her mother's role and the whereabouts of her advocate sister. In Amy's narrative detailing her trust in the midwife Constance (printed in full earlier in this section), she was simply not interested in being given all the facts about childbirth.

In that situation, Amy was happy with the limited amount of knowledge that she had at the time, confident in her midwife's competence, and bolstered by the presence of her husband. She was aware that she did not have all the available information, but she had made a decision not to seek more knowledge. This narrative is typical of those health encounters in which the women regard the acquisition of knowledge as unnecessary or unwarranted. These times often were perceived by the women as low-risk situations, either when the health condition was relatively uncomplicated, or when the women had developed such trust in their practitioners and advocates that they were able to completely rely upon them to make sound health care decisions on their behalf. Knowledge seemed to be most salient for the women as they worked to establish trust with the practitioner within a developing relationship.

Knowledge clearly had a major cognitive impact on the trust experiences of these women. Information about health conditions, their management and treatment, the delivery systems and personnel all influenced the manner in which they thought about their states of health and the ways they chose to relate to their practitioners.

Knowledge reduced their fear of the unknown, and therefore effectively reduced their dependence on the practitioner, instead enabling them to be active participants in managing their own health care.

Because, perhaps, it could have such an important effect on the women in this context, knowledge also engendered some powerful emotional responses in the women. These emotions were most recognisable in the negative experiences as intense fear and anger (both responses to threat), but also evident in the positive experiences as the rich feelings of warmth and security that the women expressed in being empowered and respected.

Theme 3: Affirmation

This theme, affirmation, encompasses those aspects of the women's trust relationships with their PHCPs that they experience (negatively or positively) as endorsing, acknowledging, or affirming them as human beings with uniquenesses and inherent worth as individuals. Affirmation is a statement of belief in the woman as a person: *"It's a validating thing"* (Jane, W#5:1857).

Sense of Self

Affirmation, as the word is used here, concerns the woman's deep sense of self, her inner being, her Soul. Following Walsh (1999), in using this word Soul I do not mean to imply a particular theological view. Rather, I use the word to refer to the transcendent dimension of an individual that has to do with the core of her being or

her essence, and which she experiences in her life and relationships as particular qualities of “depth, value, relatedness, heart, and personal substance” (Moore, 1992, p.5). Soul is intimately related to a person's feelings of self-worth, self-esteem, the construction of self that is formed and sustained in relation to others, and her sense of place in both the natural order and the divine (Herman, 1992).

The theme of Affirmation embraces those aspects of their trust in PHCPs that the women in this research lived at their deepest level; those trust experiences that had an impact on their Soul. The impact of such affirmation can be profound. It is implicated in the experiences of ‘instant’ trust that Melissa and Jane had in first encounters with their GPs, and the complete breakdown of Louise's relationship with her dentist after he had shattered her trust at this level.

Personal Acknowledgement

Affirmation included simple acknowledgement of the patient as a physical presence in the practitioner's waiting room: “I wanted someone to even notice that we were there” (Melissa, talking about a wait of three hours for medical attention. W#4:188). Melissa and Amy described such acknowledgement from their GP (they turned out to go to the same GP):

Melissa: ...he's absolutely charming and just so friendly and nice.

Amy: He is. He's very nice.

Melissa: He completely relaxes you the moment you meet him.

Amy: Even if you're not there seeing him, he recognises you when he comes out and acknowledges you like his own...

Melissa: Yes. Yes.

Amy: He'll nod, acknowledge that he remembers your face.

Melissa: Yeah – he's incredible. (W#2:1695)

This courtesy, a natural, friendly personal interaction between the parties in the patient-practitioner relationship, was also detailed by Emma. It was understood as a person-to-person connection that, in effect, left the women feeling 'special' – they had been related to sincerely as individuals and not just another patient on the day's job-sheet. Beneath the personable simple greetings of the PHCPs lies respect for the individual identities of the women.

In sharp contrast, are the women's stories of health care encounters when they were ignored (Melissa), left alone (Louise), treated without feeling as "just a thing" (Melissa), or dismissed (Jane). Jane related two incidents in which she was symbolically cut off from the caregivers. In the first she and her son who had developed septicaemia from a cut lip were shifted at 11.30 p.m. into a room without bell access to the nurses' station, a gesture that she interpreted, in the context of the entire encounter, as a 'disconnection'. In the second incident, she was left, 'shut in', in a cubicle with the curtains between her and the staff firmly closed.

Validation

Validation of the woman's own evaluation of her well-being (or diminished well-being) was experienced as the PHCP trusting in her innate wisdom as an individual. This respect of her assessment was lived as an affirmation of her as an individual and her capability to make a valid appraisal of her own health:

Jane: The first time I went to him, absolute first time I went to him, I said, "I think I'm becoming a hypochondriac. I've had these problems for the last six months and I must be going batty." And he did an exam and he said, "You've got sinus problems. You're not a hypochondriac. We can do something about it." And I was like "Thank you God. Thank you God."

I didn't know what the problem was. [I thought] it was flu, I was taking time off, my head, you know...I finally thought, "Shit, I'd better see a doctor" but I didn't know one in Hamilton, because we only moved there March that year, and Den... I wasn't going to go to his, since he was ancient apparently, so I asked someone at work and she said, "This is my doctor." So I rang up..."Yes, he is taking new patients." Fine. And it was from that, you know, from then on when he chucked me on antibiotics and said, "No, you need this," that was it - relationship established.

Louise: That's the line I used with my GP: "I think I'm going mad." And the reassurance from him: "No, you're not."

Emma: Yeah, I've had the same experience with my GP...the one I'm with now...Yeah, when I was having problems with a bit of depression and I went in and told him what was going on, he said to me, you know, he reassured me. He didn't make me feel like I was a freak because I had depression. He basically said, "Look, this is perfectly normal, you are not mad. It's quite all right to feel like this and here's what we're going to do about it."

Melissa: When I first met my GP... and the reason I got such a good relationship with Raymond is because I took Samantha in ... she was really sick... she started off with a little sore on her bottom and by the next day it was this...

Emma: ... huge abscess

Melissa: ...and by the time I took her in I felt so bad, you know, I felt about this tall and I just knew he was going to think that I'd been neglecting this child because there was no way this sore could get that big overnight. But he just said to me, "Melissa, it's this bacteria. It probably got that big in a matter of hours. You have not done anything wrong," and I thought 'Wow, I didn't do anything wrong. I am a good mother.'

Jane: That was my GP...he told me "You are actually sick. There's something wrong with you. And you're not a hypochondriac." (W#4:1540)

At other times the reassurance was felt more directly by the woman at her Soul level.

In the following narrative the midwife related to Jane with sensitivity and compassion

- practitioner behaviour that preserved the dignity and integrity of the patient, and honoured Jane's construction of the situation:

Several months into the pregnancy, after the morning sickness had passed, things started getting bad. Jane stopped going to church on Sundays, using the excuse that she needed some rest. Her husband took the two little ones himself, and put them into creche. The summer seemed to last forever with heat and humidity, and that didn't help.

Then sometime soon into the last trimester, it seemed like a black cloud descended. She was driving over a bridge with the two children in the car, and it was as sudden as that. Everything just seemed too much to cope with. The marriage wasn't that great, the children exhausting, it was really hard to keep up a front for outsiders, and then this black cloud feeling – like there was no hope at all.

Shortly after that, Jane was at a midwife's visit. The usual stuff was done, and then she came out with it: "Deliver this baby soon or you will have to deliver it at Tokanui [a residential mental health facility]. I just can't cope with being pregnant any longer."

The midwife was fantastic. This was the third baby in as many years, so the relationship with the midwife was well established. It also seemed that there was no-one else to talk to – God was fast taking a back seat, and husband didn't really have much idea of the inner turmoil because there was no way he would understand.

But the midwife did – and promised to look into the matter. Physically very imposing, she gave confidence to Jane that maybe things might work out.

The midwife was good to her promise, and just under two weeks early, Jane went to hospital to be induced with her third child. It was over the objections of hospital staff, including some very senior people (there was no medical condition that justified an induction) but the midwife put Jane first, Jane having confided just how bad things were. Basically a situation of total trust. (W#1:p.20)

In comparison, Louise was shattered physically and her trust in the dentist destroyed at the end of an encounter during which he denied vehemently both her 'insider' knowledge of her state of health and her assessment of the situation:

Louise was having major trouble with a tooth. One in the bottom jaw, just off to the left. It was very tender to the touch, and the pain extended a little way either side of the tooth, along the jaw. She had been getting very bad headaches up the side of her face, through her temple, and across her forehead. Finally, she had gone to the dentist and he had drilled into the tooth. And taken the lid off a can of worms. Spent some time dealing to the trouble, and then, because the time was up, put a temporary top on the tooth.

Today is Saturday. Louise makes an emergency appointment with her dentist to have the tooth seen to. The neuralgia is awful. Her jaw is throbbing and her head is pounding. She is vomiting. She rings the dentist at home, settles on an early-afternoon appointment, and then immediately phones her closest friend, Sally, to ask her to come and mind the children (five of them, including a nursing baby) while she is away. Sally has 6 children of about the same age as her own, baby too. Louise is very conscious of the size of the favour she is asking of Sally – “Good God, she has six young children of her own to look after. And it is the weekend!” But she can’t think of anyone else who would be likely to come. “Sure,” says Sally. “What time do you want me there?” Louise is weak with relief. Sally arrives and shushes Louise off. Not phased. No physical indications of being ‘put-out’. “I don’t know how long this is going to take,” Louise tells her. “Don’t worry about it,” replies Sally. “We’ll be fine. You take as long as you need to.”

Louise gets into the car and drives off, leaving Sally in the family room and 11 children scattered about. It amazed her that Sally was prepared to do this. Louise finds the door of the clinic unlocked, as she had been told it would be. It seems odd to be here – no one on the streets, letting herself in, up the stairs to an empty front-desk, no one bustling around at all. The door of her dentist’s room is open so she heads right in.

The dentist is quiet and busy. Louise feels absolutely awful. There is no eye contact. No small talk. She climbs onto the chair. He administers a painless injection, waits a little and then begins. Takes the temporary top off the tooth and starts the big clean up. He’s using little tiny brushes like chimney-sweeping brushes, different sizes, changing them close in front of Louise so she sees every move. It seems to be taking him a long long time to do this. He is muttering – about how badly infected the canal is, how it is still not cleaned out each time he withdraws each of the brushes. He is also huffing as

though he is annoyed – annoyed at being called in to work, annoyed that it is taking so long. Louise feels guilty.

She lies there and tries to make herself relax so that she is making it as easy as she can for him. She feels the metallic contact of the brush on the tooth nerve every time he pushes it in. “When on earth will it be finished?” she wonders. And wills her body not to tense in anticipation of the next hit. She tries to relax absolutely in between hits, the same way she had used to rest between contractions in childbirth.

There is a break in the work. Maybe if he knows how sick she has got with this he will understand that this has really been an emergency call-out: “I’ve had this headache for days now, and had it off and on for several weeks – it feels like it’s connected to that tooth somehow. The pain goes from my tooth right the way up the side of my face and into my head.” “It’s most unlikely that your headache has been caused by this tooth,” he answered. “I’ve never heard of a tooth causing headaches. Never seen any reference in any of my textbooks to that sort of thing at all.” Louise is taken aback. Shot down. Embarrassed – by his abruptness, his lack of finesse. Then indignant. “What?” she thinks to herself. Even with her limited knowledge the connection is perfectly plausible, obvious almost. She does not challenge him.

The work resumes. Louise does not initiate any more dialogue. The dentist continues to mutter, sigh, and shove the brushes into the tooth. Physically, Louise is feeling terrible. She is also angry at the dentist: “He has no right to behave like this – trying to make me feel bad for doing this. And implying that I’m imagining the tooth is causing my headache. And what sort of dentist is he if he really doesn’t know that an infected tooth can trigger headaches?”

The work takes one and a half hours. Louise gets up off the couch, and leaves the room as quickly as she can. She heads straight for the clients’ toilet and vomits. She is spaced out, exhausted, and very sore. Louise rinses out her mouth at the basin, summons her dignity, and returns to the dentist’s room. “Thank you for seeing me today,” she says politely. He is still unable to even pretend to be gracious.

Louise drives home. Sally takes one look at her, sends her up to bed, and gathers up the 11 children [six of her own and Louise’s five] to walk them back to her house: “Don’t worry about anything. I’ll feed them – you call me when you’re awake.” (W#4:2486)

Louise's trust in the dentist was destroyed by this experience; she did not return to him. That she had to consciously re-assemble her dignity points to the damage sustained at the Soul level during this encounter. Some of her responses to the dentist (cooperation, politeness, dignity) and the sensitive, selfless, caring reactions of her friend provide a powerful foil to the dentist's behaviour.

The women's stories, both their written narratives and the stories that they told during the group-work, revealed a range of responses to health care events that injured their sense of Self. Like Louise, Melissa got very angry when she was not acknowledged or attended to. However, she fired back at the openly hostile nurse and expressed this anger verbally. The women decided collectively that a woman's response to negative affirmation by a PHCP depended to a large degree on the Self-health of the patient. Thus, Jane acquiesced and remained silent in the face of ill-treatment at a time when her self-esteem and inner strength were depleted (W#2:1320). At the other end of this range are those responses that the women have turned in on themselves – Emma's anger at herself when the GP performs a particularly insensitive cervical smear procedure (*"God, I was such a mug!"* W#3:1182); Jane's condemnation of herself as stupid for letting a practitioner "use" her son to prove a point (W#2:1333); and a tragic incident (recounted by Melissa) when a mother's concern for her baby was discounted summarily and her child died in the waiting room, the mother too cowed to speak out again (W#4:3474).

Individualised Care

Underlying the women's experiences of positive affirmation is a sensitive individualisation of the health care delivery. PHCPs whom the women trusted treated them as individuals, taking into account each woman's specific needs at the time, and addressing the health concern relative to the woman's circumstances and lifestyle: her health care was tailored to fit her. These PHCPs checked in regularly with the patient during the actual treatment:

[The osteopath] finds a painful spot, and Emma winces. Cushla apologises to Emma, and says that this area will be tender, but that she needs to continue to try and lengthen the muscle again. Emma nods. She tells Emma that if the discomfort is too much for her to let her know. Emma says OK, and Cushla continues. (Emma's narrative, W#1:p.30)

When appropriate, the PHCP helped the woman to manage the impact that the condition would have on her life outside of the consulting room:

[The optometrist] invited them to sit down for a chat before he examined Amy's vision. Even the 'chat' was different. Instead of the usual 20 questions as to how Amy had acquired presumed ocular histoplasmosis, Gustav focussed on how Amy was coping with this disease. Coping? Since when had anyone asked about how she felt?

True, the eye specialist was very caring but he was, after all, a specialist, not your everyday optometrist. Gustav seemed to already know a little about her eye history anyway. Must have had a chat with the specialist. So, how was she coping? Not very well, actually. "Boy, I thought I was just here to get new contacts!"

Gustav started to explain that he had lots of tricks and techniques to help 'low vision' patients. Contacts would only help so far in correcting her sight but there were quite a few methods that could be used to aid the problem and help her cope. He began to demonstrate different types of magnifying glasses and lens, binoculars, etc. Wow, this stuff is cool and fun to play with.

"Choose what you like and think would be helpful and take them home with you to experiment with," Gustav said.

" 'Take them home?' OK, I'm impressed," she thought. "And we haven't even gotten to the exam yet."

Gustav even asked her how she was coping in the job, considering that she did a lot of writing and reading. Amy said her boss was great and was willing to buy her 'aids' and do whatever he could to help. They talked for a few minutes about computers and the options for improving her ability to see the screen. (Amy, W#2:34)

Commonly, this type of approach resulted in the woman feeling valued and respected, endorsed her initiative, and enabled her to maintain her autonomy and confidence as a patient. Some of the women initially reacted with suspicion to unexpected individualised care and concern from a PHCP, while others responded positively at once. Regardless of the initial reaction however, individualised care by the practitioner that respected and affirmed the woman at a deep level of self was common in the women's positive trust experiences.

Theme 4: Voice

Voice is another key thread that is woven through the women's work. Because this research concentrates on understanding the experience of trust from the patient's perspective, this theme focuses entirely on the patient's voice in the relationship between her and the PHCP, and the perceived response by the 'audience' to her communications. The theme centres on the belief that each woman has something to say, that her point of view counts, and finally, that she has the right to express herself without fear of ridicule or censure. Furthermore, as a human being she has the right to a 'hearing', in this case from the others involved in her health care.

Self-Expression

The theme of voice, as it is used here, refers to the woman's expression of her needs, her experience, her feelings, her reality, her thoughts throughout the health care encounter:

Amy: So there's a 'trust' in being able to tell the practitioner what to do, and that there is a history, and there are feelings about a particular place (that being the hospitals), and them taking that on board, and taking it seriously...and not bemoaning or pooh-poohing those feelings. (From collective analysis of Amy's and Louise's fear of hospitals, W#1:92)

While this communication is often verbal, it can also be conveyed without sound – through facial expressions, body language, and even silence as 'no voice'. This section reflects that range.

Silence

Silence, in the sense of 'no voice', ran throughout the women's stories, but was most common and most distressing for the women in their negative trust episodes, for example Emma's silence throughout her cervical smear, and Louise's silence during her emergency dental care. This type of silence was experienced, understood, and theorised by the women as not speaking 'our truth'.

However, Silence also was detailed within their positive experiences. Melissa discussed times that she chose to stay silent with her GP because of the deep trust she had in him:

I can trust him [GP] to do what's right....I would always give him the benefit of the doubt....I would always give his idea [a particular treatment] a go first, because I have that level of trust that I know he would change his mind if it's obviously not working. (W#2:1172)

Melissa also talked about being quite prepared to remain silent during a three-hour wait for emergency health care: *"I knew that the staff were busy...I knew that it was an emergency room and I know you have to wait"* (W#4:543).

In excerpts from Louise's narrative about the home-birth of her first child, we discover more qualities of the silence that can occur as part of positive trust between a patient and her PHCP:

The doctor arrives after the baby has been born. He [the GP] is in the family room when Louise returns from cleaning herself up in the bathroom. He and Rosalind are talking about the placenta, which has not yet appeared. (Louise is walking around with a bucket between her legs.)

Rosalind takes Louise into the hall and tells her that the doctor has said that if the placenta is not delivered within a certain time then Louise will have to be taken up to the hospital for an extraction. It takes Louise a moment to get her head around the change in atmosphere. She is taken aback at the apparent urgency of things now, but does not waste time arguing or asking. Rosalind is very serious – close and insistent. Focussed.

Louise and Rosalind move back to the bathroom and following Rosalind's instructions, Louise bears down. After what seemed like a long time (long enough to get scared that this wasn't going to work) the placenta is at last delivered. Thank God. Together they have averted a trip to the hospital. Proudly the two of them present the placenta in the bucket to the doctor. He leaves soon after. (W#1:p.28)

The 20 Questions

Also evident in both the negative and positive experiences were what the women labeled “The 20 Questions”. These were the questions that the PHCP used to build the patient-history. In their negative stories, The 20 Questions appeared as a set of standard questions that were asked as a matter of routine, were not varied to better suit the patient's health circumstances, and were asked without feeling. In these circumstances, the patient responded in answer to the 20 Questions; she spoke when she was spoken to. Patient expression was very tightly managed by the practitioner, who constructed a history on the information extracted from the patient.

The women lived this sort of history-taking as a frustrating experience: *“Been there, done that [The 20 Questions] twenty thousand times - and I hate doing it”* (Jane, W#4:2176). During their collective analysis and theorising on The Usual 20 Questions, the women described the PHCPs who had used this approach as offhand, arrogant, patronising, and dismissive practitioners who did not give the patient time to respond fully and often appeared to not be listening to the answers anyway.

In their positive stories of trust, the women described very different experiences of The 20 Questions. In these experiences The 20 Questions disappeared as a unified set and instead, the relevant questions are interspersed in larger conversations that felt more like a conversation to get to know the patient than a formal history-taking. For instance, a very thorough, individualised profile of Amy and her state of optical health was largely put together during a ‘chat’ that took place in what she described as a mini-lounge area:

Amy: [The optometrist said] "Let's sit down – let's have a talk about this." [He was] really trying to get to know what my situation was. 'What do you do for a job?' and whatnot, to determine what he was going to suggest in terms of aids... We had a long talk about the computer.

Jane: He was going to fit the aids and things to you rather than fitting you to the aids?

Amy: Right. And he sat there and told me stories of other clients he had...and what they had done and how they were coping. (W#2:448-457)

Dialogue

Moreover, in their trust relationships, these women felt able to volunteer information, ask questions, challenge an opinion, and/or disagree with advice given by their PHCPs. Their Voice is engaged in dialogue with the PHCP. In these relationships, they felt able and safe to express themselves honestly:

Midwife Rosalind arrives, has Louise lie down so she can check her and baby. Then they move into the bathroom so Rosalind can give Louise an enema. Rosalind checks again with Louise that she really wants one, gently points out again that it is not necessary. Louise assures her that it is what she wants. Duly administered – the first of the birth indignities, a weird thing to be asking Rosalind to do – she's become a friend – this crosses the line somehow – Louise exerting some sort of 'client right', not taking her advice. Enema successful.

Louise busies on. Not phased. Calm. Husband Matt arrives home with their eldest Son (8) who wants to be a part of this birth – both excited. But still Louise is nonchalant. Laid back. Not scared. In control. (W#1:p.26)

In contrast, these women found that in their negative experiences when their voices were at odds with those of their practitioners, the PHCPs attempted either to drown out their voices or to shut down the dialogue entirely. Frequently the women spoke about encountering PHCPs who reacted with a "I am God and I am the Word" rebuttal

(e.g., Amy, W#2:853); others who tried to “baffle with bullshit” (e.g., Jane, W#2:276); or those PHCPs who dismissed the patient either with a direct denial (e.g., Louise, W#4:2527) or by simply ignoring what she had said (e.g., Melissa, W#3:220). The women also described encounters when the PHCP had chosen not to engage in any personal conversation, because they were perceived as lacking the necessary interpersonal skills (e.g., Emma, W#3:663); or just did not care, as in Amy's story of a GP she dealt with at an accident and emergency clinic:

We had an older male doctor very early one morning who didn't really look at my daughter as a person at all. So she decided to teach him a lesson and threw up on his shoes and his response was “Well, I don't care – this is not my office.” I don't know whether it was the end of his shift or what the deal was. It was like: “OK, let's just pump this kid with antibiotics. Bye.” (W#2:963)

With-holding Truth

Another interesting Voice issue relates to those times that the women speak but do not speak their truth. This is a common enough social response-etiquette in everyday life (The “How are you?” “Fine.” routine), but within the health care context it means that it is the woman herself who effectively trivialises her condition, or minimises her pain. Louise provided a clear example of this untruth-telling in her hospital birth narrative when she was very frightened but proceeded to tell the doctor she was fine (W#3:1257).

In summary then, these four themes of vulnerability, knowledge, affirmation, and voice contain the common patterns that the women used to make sense of their trust experiences, as they related specifically to the individual woman. These four themes thus constitute the ‘She’ domain within the relational heuristic that the women used

throughout the research, and upon which this analysis is based. The following section presents those aspects of trust that these participants understood as relating most to their PHCP – the Primary Health Care Practitioner as the 'Other' of the device.

6.4 The Primary Health Care Practitioner as 'Other'

In the relational heuristic, Primary Health Care Practitioner as 'Other' refers to those dimensions of their trust experiences that these women perceived as being centred on the practitioner, as the Other key individual of the primary health care relationship.

These are those aspects that these women perceived as mainly attributable to the practitioners and originating from them: attitudes, beliefs, emotions, and behaviours that originated from the PHCP, were exhibited in relation to the patient, and for which the PHCP, ultimately, was responsible.

The women described a range of responses by the PHCP that they perceived as central to their trust experiences with these health care providers. These PHCP responses were experienced in different configurations by each woman, according to individual circumstances such as the specific health care situation that had driven each encounter and the PHCP with whom she was relating. Nevertheless, despite the individual configurations, the following set of common PHCP responses provides us with valuable insights to the responses that the women found characterised their experiences of trust (positive and negative) across their health care encounters.

The PHCP responses are presented in two sub-sets. The first sub-set is comprised of those responses that relate primarily to the 'cure' or scientific-technical facet of the

PHCP's delivery of service; the second group of responses relates mainly to the 'care' or psychosocial elements of the service. This differentiation follows models of health care service delivery developed by researchers over the past decade (e.g., Carmel & Glick, 1996; Gabbott & Hogg, 1995; Turner & Pol, 1995).

The scientific-technical facet relates to the 'medical'/'science' content of the health care delivery: specifically, what health care is delivered. In other words, this facet focuses on the PHCP's intellectual and technical capability to deliver 'health' to the patient – how proficiently specialised health expertise and knowledge are applied to the assessment, diagnosis, and treatment of a health concern. The psychosocial facet relates to the PHCP's interpersonal skills – this is the subjective dimension describing how the health care is delivered. These distinctions are based on the classic service model proposed by Gronroos (1984) in which he divides service performance into the 'technical' or 'instrumental' dimension, and the 'functional' or 'expressive' dimension.

'Cure' or Scientific-Technical PHCP Responses

This set of responses, as perceived by the female participants, relates to the scientific-technical expertise and skills of the practitioner, and the PHCP's proficiency in applying these to the health care of individual patients.

Theme 5: PHCP's Clinical Skills

This theme relates specifically to the technical and experiential skills of the PHCP to deliver health care. It was a relatively straightforward and well-understood key theme among these women, which was experienced, from their perspective as patients, as a basic pre-requisite in their expectations of the providers of their 'health care'.

Accuracy and Appropriate Treatment

In their positive experiences of trust the women perceived the PHCPs as skilled specifically in accurate diagnosis and appropriate treatment: *"My GP would know what to do...he would fix it...he would deal with it...whatever needed to be done."* (Jane, W#4:1476). These PHCPs worked to deal to the health concern quickly and efficiently, in order to relieve the patient's immediate pain and/or symptoms short-term, and improve her long-term well-being. The patient's health concern (the primary reason for the encounter) was regarded as the first priority by both the patient and the PHCP. Accurate diagnoses and appropriate treatment were perceived to demonstrate competence and expertise. In turn, these participants regarded PHCP competence and expertise as key indicators of trustworthiness.

In the following extract the group explored how Louise related the technical skills of her chiropractor to her construction of the trust she experienced with him. She had presented with a migraine, which she usually had to treat with self-administered injections, but this time the chiropractor had been able to treat the migraine successfully with spinal adjustments.

Jane: When you walked out and you thought, "Wow, I've been medicated without medication basically", were you thinking about trust issues?

Louise: This might be a roundabout answer, OK? When I got that same sensation that I do from the injection, which is absolutely unmistakable and it's a prickling that goes around the back of your head/neck area, and it was "Wow, this is happening without the drug"....It became a testimony to the chiropractor's ability....The physiological reaction I had was incredibly important....It was proof

Amy: Right – "proof".

Louise: ...that he was a successful practitioner. (W#2:2030)

For all five of these women, the clinical skills of the PHCPs figured largely in their experiences of trust. Usually, the women interpreted these skills at a cognitive level as a demonstration of the practitioner's scientific-technical capability, understood basically as the core competency of the PHCP (e.g., Emma's high evaluation of the clinical competence of the osteopath, W#1:p.30). However, at other times the women perceived these skills in more complicated ways as testament to the practitioner's interest in individualising the health care service (e.g., Amy's experience with an optometrist who had researched her rare eye disease before her first consultation, W#2:463) and they were then often experienced more at a Soul level by the individual person.

Theme 6: Responsiveness

In the work deconstructing narratives written on the trigger topic "Describe a time when your primary health care practitioner demonstrated that s/he was worthy of your

trust” the women not only emphasised the importance of the PHCPs’ skills and competence, but also stressed the need for responsiveness:

Louise: They [PHCPs] react to what we’re telling them without challenging it...which is what makes the responsiveness so important - it’s in response to an innate feeling that something is not as it should be.

Melissa: It’s like when Jane says to her doctor “Something’s not right.” He doesn’t say to her “Damn woman, you’ve been up there [the hospital] twice, they’ve done all these tests, they haven’t found a thing. You’re crazy.” He didn’t say that. He went with what Jane was feeling and said, “OK. So you feel something’s not right – then something’s not right.”...

Jane: He took bloods and said, “Right let’s see where things are at.” And the next morning, Saturday morning, [I made a] cellphone call to him: “Look. I can’t do this. I’m just in so much pain.” “Right. Come and see me. I’ll let you in the clinic. (W#2:2700)

Willingness and Speed

Two distinguishing elements of the women’s understanding of responsiveness were willingness and speed; the women perceived a gracious readiness in these PHCPs, coupled with a definite sense of timeliness: “*I just have to say what the problem is and he [the PHCP] is there checking it out*” (Jane, W#2:2722).

Those PHCPs who were unable to diagnose or treat the health problem openly admitted this to the woman, and consulted texts or colleagues, and/or referred on to another practitioner with more expertise. Underlying an experience like this was an assumption, on the part of the woman, that the responsive PHCP had:

- (1) a working knowledge of the health care delivery systems; and
- (2) access to a full range of health care professionals from which the practitioner would be able to decide which would be best able to help the patient.

Melissa's individual narrative ("The most important time I have trusted a primary health care practitioner") about a health care encounter at an accident and emergency clinic after her son had broken his ankle, contained a clear example of a PHCP willingly referring on the patient:

Then something incredible happens. Standing in front of her is a young doctor informing her that she is sending them up to the hospital because this is something she is not qualified to deal with. "If this break heals wrong," she informs the concerned pair, "he could have trouble walking for the rest of his life." She then makes a phone call to the orthopaedic specialist outlining what she has found and requesting that he deal with it as a direct referral so they wouldn't have to go through the hospital ER system.

This turns out to be a God-send because while waiting in the hospital's emergency room for the specialist to finish in surgery Melissa hears the hospital doctors discussing the x-ray at which point both of them declared there was nothing wrong with it. Not a fracture in sight. But shortly afterwards the specialist arrived and confirmed everything the young doctor had told them at the clinic. (W#1:p.22)

The women set such experiences against those in which PHCPs who did not have the knowledge or expertise to deal with their immediate problems, reacted with variants of what the women coined the 'I-am-God' response. This set of negative responses was perceived by the women as an indication of professional and/or personal insecurity in the PHCPs:

Melissa: A large part of trust is the knowledge that they will admit when they can't deal with your problem...being secure enough in themselves to admit that they don't know.

Louise: Yes. Which really is still keeping your interests at heart. Not 'my need to be secure' or...

Amy: Or powerful. Or high-and-mighty-doctor. (W#5:2219)

For Melissa and Jane, the responsiveness of their GPs was instrumental in instilling in them a deep confidence that amounted to a 'faith' of sorts; they were absolutely sure that the GPs were capable of comprehending their individual health needs, and were both able and willing to fulfill them. The women were sure, without any doubt, that these practitioners would come through for them. At the private emergency clinic (after a three-hour wait at the hospital) where she had taken her son to have his ankle seen to, Melissa found herself thinking:

It doesn't matter – I'll see Raymond [GP] in the morning and he'll fix it....I said [to emergency clinic doctor] "Don't worry – get us through the night, Raymond will fix it in the morning."...And he did. He got us straight in to see the specialist, once again bypassed all the hurdles. (W#4:87)

During a dissatisfying after-hours emergency encounter (related to Bell's palsy),

Jane's experience of the faith she felt in her GP was remarkably similar to Melissa's:

It made me wish that I'd waited till I could call my GP....My GP would have made it right....He would have done it properly.

Louise: 'Properly' being what?

Jane: Just, you know...he would have done it properly.

Melissa: You don't know what he would have done but he would have fixed it.

Louise: You trusted your GP. He would have dealt with it.

Jane: Yeah.

Louise: Whatever needed to be done.

Jane: Yes. (W#4:1476)

Lack of responsiveness from the staff in these two situations served to highlight just how much Melissa and Jane valued responsiveness in their GPs. They believed that their immediate health needs would be better taken care of by their GPs than by the emergency staff. In effect, both women felt safe with their GPs and trusted that the practitioners would do whatever was required to ensure their well-being. Their faith

was an expression of this belief that they could rely on their doctors; this faith was based in their belief the GPs would provide the responsiveness that the clinic staff lacked. The intensity of their faith afforded an insight to the criticality of responsiveness in the women's patient-practitioner relationships, and also indicated the depth of trust they had in these two GPs.

Theme 7: Professional Confidence

Assurance

Trusted PHCPs responded to the women with surety and assurance, relational responses that engendered patient confidence in the practitioner, reassured the patients, helped to relax them, reduced their fear, and enhanced the trust experience. Louise gave a rich description of such professional confidence in her narrative detailing the behaviour that demonstrated PHCP trustworthiness in her chiropractor:

She gets up and carefully does the migraine glide across the hallway into the treatment room... There is no small talk... He rocks her head from side to side, one hand on top of her head, the other feeling the vertebrae of her neck... Louise is told to get onto the couch... He adjusts her skull and neck, telling her clearly how he needs to change her position. When he has finished he has her lie there for a while. He moves back to the desk and makes some notes. Louise closes her eyes and does not talk. He is still quiet and respectful... When it is time to get up, Dr Hans returns the couch to its upright position and Louise gets off. "I'm feeling better," Louise tells him. She is able to look him in the eye. He is quiet and assured still – no visible bristling with "Ah yes, I'm the man" practitioner pride. No bull-roaring. (W#2:1739)

Authority

At times, this confidence was lived more as a distinctive practitioner-authority when the PHCP told the woman exactly what to do, and the woman followed those directives without question or argument. For example, recall the authority conveyed by the midwife in Amy's first individual narrative:

Amy sees Constance [the midwife] leaning over her. Until now Amy has had her eyes closed, concentrating on pushing baby out. But baby keeps sliding back up. In a direct, commanding voice with a no-nonsense tone, Constance says: "Push Amy. One big push. Then we'll use the ventouse to pull baby out. Just one big push to get baby down, You can do this. I know you can." Katherine [the registrar] adds: "If this doesn't work we'll have to go into theatre." (W#1:p.23)

The women spoke about needing such authority at certain times, and respected it then as totally appropriate for the particular health care situation.

Theme 8: Thoroughness

This PHCP response relates to the examination of the patient and the history-taking, which generally precede diagnosis and treatment. Thoroughness had a much higher profile in the women's negative trust experiences than in their positive. Experienced variously as a lack of thoroughness, a token thoroughness, or an irrelevant thoroughness, these were perceived by the women as clear behavioural indicators that the PHCPs were not trustworthy. These were lived as signals that the practitioner was not competent, and/or not interested in relating to the woman as a person.

In contrast, in their positive experiences of trust, the women tended to take this PHCP thoroughness for granted; it was a relational response that the women recognised and appreciated after the encounter, on reflection. Trusted PHCPs were thorough naturally and unobtrusively – thoroughness was an integral part of the overall health care encounter. It enabled accurate diagnosis and treatment, and was perceived by the women simply as one component of a personalised encounter.

Moreover, the women perceived that these PHCPs worked purposefully at constructing a thorough understanding of their health status, in order to provide a sound base for health care decision-making. Often, the PHCP gleaned the necessary information from different sources – The 20 Questions-type standard patient history form, relevant information given by the patient, the patient's records, other practitioners involved in the patient's health care, textbooks and other data-bases.

Patient's Health Context

Emma used the metaphor of a jig saw puzzle to describe such thoroughness in her GP. Her GP had put together her health history like the pieces of a jig saw puzzle so that, finally, she was able to '*see the picture*' (W#5:1868) and understand how the symptoms she presented with that day fitted into the bigger puzzle that her overall health had become. Her husband had taken Emma to the GP for help after weeks of migraines and a run of family crises.

Her GP diagnosed depression but continued, over the course of the encounter, to ask questions that led back to critical incidents when she was a child. The sensitive

thoroughness of this GP was a key factor in enabling Emma to begin working through the trauma of childhood sexual abuse by a family member. Until that particular encounter, she had told only her husband about the abuse.

‘Care’ or Psychosocial PHCP Responses

This second set of responses, as perceived by the female participants, relates to the subjective dimension of the PHCPs' relationship with their patients - the interaction, or social, skills of the practitioners, their attitudes towards people, relational qualities such as their friendliness and empathy. These psychosocial-related responses frame the delivery of health care, that is, how the health care consumer is served. In the context of this research, the PHCP 'care' responses detailed in the following section are those that the women identified as integral to their experiences of trust with health care providers. As were the 'cure' responses, these 'care' attitudes, personal characteristics, and interpersonal behaviours also were perceived by the women as indicators of trustworthiness or untrustworthiness in the PHCP, and evidence of trust or lack of trust in the relationship.

Theme 9: Acceptance

Acceptance was the most important PHCP care response for these women in their positive trust experiences. Acceptance, as an unconditional, non-judgmental reception by the PHCP of the woman and her health concern, featured across the women's work. These women commonly experienced acceptance as a sense that the practitioner believed them and took them seriously:

Paul [Louise's GP] listens to her, asking questions now and then. Always gentle and reassuring. "What's happening to you is perfectly normal, Louise. Perfectly normal - given the circumstances." He talks to her about the 'flight or fight' response, and about domestic violence. This is not the first time she has heard about these things, but in here the cards are all on the table and she is being up front and honest with Paul. Telling him how it is. And she feels that he is respecting her by being totally honest - there are no fronts here now.

The room loses its features as she talks to him. Time has no importance. This is a moment of absolute honesty between them - one human being with another, soul stuff. And Paul seems to understand what she is saying. In some way it is a little easier, still blood-raw and full of horror, but Paul believes her - and he's taking her seriously. She is not imagining it. It is all very real. Very serious. Very bad, but he has said that she is not going mad - there is huge relief in that somehow. (W#5:105)

The women constructed 'not being believed' and 'not being taken seriously' by

PHCPs as major fears for them in the health care context: *"This is the risk here...*

'What's going to happen here? Is he going to come on board and believe and listen and take me seriously...?'" (Louise, W#5:964). The risk of not being believed or not

being taken seriously was such that at some time it had stopped each of these women from going to a PHCP for help until their health situations had become desperate and they were no longer able to cope alone. PHCPs who were accepting did not pass judgement on the women, did not lecture the women, did not belittle the women, or discount their stories.

The women went into many of their health care encounters expecting non-accepting responses (usually when their relationship with the PHCP was 'new' or immature, or when the woman was consulting about a 'new' health situation). In an earlier extract Melissa referred to such an expectation that she would not be accepted by the doctor whom she was consulting for the sore on her daughter's bottom. Her individual

narrative provided a rich description of the judgmental reaction she anticipated from the GP:

It is Friday afternoon and Melissa is getting the children ready for their weekend visit with their father, when her youngest, a daughter then aged five, comes to her and complains about a sore spot on her bottom. On inspection Melissa finds a small pimple to which she applies tea tree oil and assures her daughter it is nothing and will be fine.

On Sunday evening, after the children have returned home and while Melissa is getting them ready for bed the little one says, "Mum, my bottom really hurts." Melissa pulls down her pants to take a look and is horrified at what she sees. The poor child's entire bottom is one large draining sore, which she has just pulled the top off when she removed the underpants. Talk about guilt. However, realising there is not a lot to be done at this late hour, Melissa cleans up the sore as best she can, applies cream and puts child to bed.

First thing in the morning Melissa makes plans for a visit to the doctor. However they have only lived in this town three weeks and she has no idea where to go - because, like most people, the thought of finding a new family doctor never entered into her mind until there was a need to make an appointment. Melissa decides to make an appointment with the nearest clinic and take her chances.

"What a great way to meet the new doctor," she thinks as she walks into the clinic. "When he sees this sore he is going to think she has neglected the child for weeks. How will she ever convince him that she is really a rather good parent who does not neglect her children's health?" She thinks of blaming the ex but realises that will sound like a cop-out, though in the back of her mind she can't believe he hasn't noticed anything wrong over the weekend. By the time their name is called Melissa is almost too afraid to admit to the problem.

However, to her great relief her new doctor takes one look at the offending bottom and assures her that it is not unusual for sores such as this to appear overnight. "Even this big?" she asks. "I've seen bigger," he replies in a reassuring tone. "Well," thinks Melissa, "just think of that - he doesn't consider me a bad parent after all." (W#5:1411)

Like Melissa's GP, the PHCPs who were accepting believed the women, took seriously what the women said, and did not challenge the women's understanding or

her feelings about her health. The participants understood that with PHCPs who accepted them, the main item on the agenda for the encounter was the woman's state of health. These PHCPs so accepted the patient's viewpoint that they were able to identify readily with the woman and centred the health encounter around what she wanted to happen or was experiencing. Thus, common in the women's positive trust experiences was their perception that the PHCPs were focussed on meeting the health needs of the patient, rather than on meeting any personal needs that the practitioners might have, for instance, relating to power: "*[The GP] is the one doing the listening and trusting and not going off and thinking 'Well, I am God.'*" (Amy, W#2:852).

Impartiality and Unconditionality

These women trusted that the PHCPs who were accepting 'were there' for them, "*without question, no conditions*" (Jane, W#3:3213). Accepting PHCPs did not make the women feel inadequate (e.g., "*He didn't make her feel like a total failure because she could only see the big E on the chart.*" Amy, W#2:54), or that they had to justify the need for their visit or explain themselves (e.g., their health realities, their symptoms, or their behaviour). In these cases, the women lived these patient-practitioner relationships as unconditional; insofar as the individual woman was able to depend upon the practitioner to treat her without judging her as a human being, evaluating her, disapproving of her, or censoring her. For example:

- *Melissa: I know that no matter what my problem is, I can go to Raymond [her GP]...*

Amy: And you're not going to hear 'Good parent/Bad parent'.

Melissa: No. It's not a 'Good/Bad Parent' thing. And I think even if I was a bad parent...

Amy: He wouldn't be judgmental. (W#5:1581).

- *Jane: He [a PHCP] came straight out and said "Are you sure this isn't all in your head?" (W#3:2316).*
- *Melissa: He accepted my problem on the face of it without saying, "It's not possible that the radiologist was wrong. You have to be wrong, not the radiologist - he's the professional." He was totally willing to accept that, yes, I could have been right (W#2:895).*

Instances when these women felt that they had been judged by a PHCP commonly occurred in hierarchical patient-practitioner relationships where the women perceived that the practitioner was using power and control to secure the dominant position. In encounters when the PHCP was accepting and the woman felt respected, the patient and the practitioner were able to work together, with the focus of their interaction on the woman's health.

An important part of acceptance, from the perspective of these women, was the PHCP's response to personal differences between the practitioner and the patient. Points of difference were respected by the PHCPs who figured in the women's positive trust experiences. These practitioners were able to empathise with and focus on the patient despite the differences between them as individuals. The women felt 'honoured' by relational responses like these; such behaviour honoured the women's basic human right to be different.

However, it was evident from the women's work that they experienced 'degrees' of acceptance from their PHCPs, ranging from non-challenging, non-judgmental responses to advocacy. In trust experiences where the women perceived that the PHCPs were prepared to become advocates for them, the practitioners stood up on her

behalf for her needs, wants, and rights (both as a person they were in relationship with and as a patient whose health care they were involved with).

In these instances the women felt as though the PHCPs had not merely accepted the patient but had suspended themselves, as it were. These PHCPs made the patient's needs paramount, and put aside their own worldviews, 'health-views', and self-interests in the interests of the patient. Some of the women felt as though, at times, the PHCPs risked professional relationships or reputations to do this. This perceived willingness by the PHCP to breach standard health care protocols or systems by standing up for the patient was evident in Amy's description of her midwife,

Constance:

Amy: ...she didn't take any flak from doctors...if she thought that something was going astray or not quite right or that they weren't doing their job she'd let them know.

Emma: Yes. She was your defender.

Amy: Yes. As well as being reassuring and calm to me and knowing what I needed. And knowing that I was scared and that she had to focus on helping to alleviate those fears.
(W#5:1393)

PHCP acceptance of the women and their experience of health and ill-health endorsed the individuality of each patient and emerged as crucial to a trusting patient-practitioner relationship for the participants in this research.

Theme 10: Personal Connection

This care response relates to those PHCP behaviours that the women perceived contributed toward them feeling like persons – and not merely diseased bodies on a clinic examination table. In positive trust experiences, the PHCPs related to the

women as individual human beings first and foremost, rather than as patient-objects. The women perceived that these PHCPs were focussed on them during the encounter, that the practitioners were right there with them, in the moment. The practitioners made sincere efforts to establish a connection with the women on a personal level, and to understand the individual and social circumstances of the women's lives.

Patient's Life Context

These PHCPs were genuinely interested in understanding the women in the context of their life-worlds, encompassing health, emotional, social, family, work, financial, and/or spiritual aspects. In an excerpt taken from her individual narrative used earlier, Amy recounted her surprise at the optometrist's genuine interest in her as a person:

I was just blown away because he did not just immediately put you in the chair and start examining you...He sat down and he talked to me, and asked me how I feel, and how I do my job, you know, 'What do you do for a living?' 'Is work being responsive to these needs?' and everything. Far out! I thought: 'You have definitely earned my trust because you are looking at me as a person.' (W#2:93)

Patient's Best Interests

Because these women felt as though these PHCPs knew them as human beings, they were able to trust those practitioners to work towards their best interests:

"...this GP knew her and knew what was acceptable in terms of coping at home and what wasn't. Much as she did not want to comply, Jane didn't have any real choice and she had to trust his knowledge of her body and the way it worked." (W#2:2535)

PHCP's Listening Skills

Listening was central to this PHCP response; listening that the women had experienced as intense and complete concentration on them and their stories, by practitioners who were not distracted, but whose primary concerns were the here-and-now issues emerging during their encounter with the patient (e.g., Amy's experience with the optometrist). Astute PHCP listening and attending to the details of the situation prompted the women to open up more to the practitioner, at times entrusting the practitioner with knowledge that she had not shared with anybody else (e.g., Louise's confiding in her GP about the domestic violence).

PHCP Intuition

The women also detailed in their discussion a characteristic of their trusted PHCPs that they labeled 'intuition'. As the participants experienced it, this PHCP intuition was a special aspect of the genuine-interest response, felt by the women as the PHCP 'knowing in advance' what was going on for the patient and what her needs were:

- *He [Emma's GP] asks Emma how he can help, although he seems to already have guessed (W#5:1764).*
- *Melissa: Once you've told him [GP] you realise that he knew all along anyway (W#5:1820).*
- *Jane: She [the midwife] has got a knack...I didn't have to say everything that was going on (W#5:1568).*
- *She is aware that Dr Hans has sensed she is not her normal self (Louise, W#2:1740).*
- *Constance [the midwife] can see the pained and scared look on Amy's face. "Don't worry," she says. "I'll go with you into the operating room and hold your*

hand.”...And throughout the entire procedure, Constance stays with her, holding her hand, talking to her and reassuring her. (W#5:1036)

- *Melissa: It was almost like he knew what I was feeling and he addressed the exact emotion that I had (W#5:1537).*

So, there were moments in their relationships with these practitioners when the women experienced the PHCP understood or recognised what they themselves did not; the PHCP was able to see the whole picture and comprehend the woman's place in it even when she could not. Heidegger explained this type of fore-thinking as a “leap” (1927/1962, p.158), when one person responds to a “soundless saying” and leaps away from familiar patterns into the realm of another. The women regarded this intuitive knowing-in-advance as evidence of a special, deep connection between the patient and the PHCP as human beings. It emerged as one of the distinguishing characteristics of the PHCPs that these women trusted most.

Theme 11: Honesty

Prognosis

PHCP honesty was identified as a critical factor in the women's experiences of trust in their health care relationships. These participants valued honesty from the practitioners about their ability, or more specifically, their inability to meet the women's health needs at the time. Thus, in the women's understanding, PHCP honesty was experienced as a 'care' dimension to their trust experiences, insofar as it indicated an open truthfulness by the practitioner in their interactions with the patient. However, the subject of this relational Honesty generally concerned 'cure'-related

aspects; notably the practitioner's ability to assess, diagnose, or treat a specific condition. These participants appeared not experience or make sense of honesty relative to the 'care'-related aspects of their health care experience.

All of the discussion around the theme of honesty centred on encounters in which PHCPs admitted they were incapable of addressing the patient's health issues because they did not have enough knowledge about a specific condition, or they did not have the necessary experience or skill to treat the problem. This sense of honesty also included admissions by practitioners that formal health care delivery protocols or systems would not meet patient needs in particular circumstances. A story Amy recounted during one group session about the treatment of her baby Katie illustrates well the construct of PHCP honesty. In this case Honesty was displayed slightly differently by the Plunket nurse [a specialist child and community health nurse], by the locum GP, and finally by the midwife:

Katie was diagnosed as having a haemangeoma inside of her lip. The Plunket nurse said, "I don't know what to do about this." Our GP was on holiday and so we had a fill-in GP and she said, "I think I know what she has but it's beyond me. She has to go a paediatric specialist because we don't know what to do about this. But I'm new. I've only been here a year." And I said "I'll call our midwife and I'll ask her [which paediatric specialist to take Katie to]."

So I rang Constance [the midwife] and said "What about this particular one [pediatric specialist]?" and she said, "Yes, I like him very much. Yes, I would highly recommend that you go to him. But we have a problem. You have a gatekeeper." (She didn't say that but in a different word - "The receptionist is going to be a real you-know-what.") She said, "We'll get through this. I'm going to tell you exactly what to say." And she didn't mind me taking notes. She said, "I know you're a smart woman. Well, I know you are not going to have any problem, and if you do you get Peter [Amy's husband]."

And so sure enough I said, "Okay I'm too scared. You deal with it." So he did. And he rang her up and said, "This is the

situation and our daughter's been referred. She needs to see him." He said "Constance could have written the script," because the receptionist acted exactly like she predicted, I mean, step by step by step, and he just pushed on through and he said, "No. We were told she has to see him. You look in your book and you tell me when the next available appointment is." He just kept on and in time she came back and said, "Well, next week." (W#2:1535)

In the positive experiences of these women, such as Amy's telephone 'encounter' with her midwife, the most trusted PHCPs followed up honesty with immediate action – they worked to identify the knowledge or the health care professional necessary to help the patient. In this sense the practitioners were still actively working in the best interests of the women's well-being; however they had assumed the role of patient's 'agent', as it were, rather than hands-on health care provider at that stage. This marriage of PHCP admission and action ensured that the women were not left feeling abandoned, helpless, hopeless, or vulnerable to the vagaries of the public health care system.

Respect

The women interpreted PHCP honesty as a demonstration of respect for the individual: respect for the woman's right to an honest response to her health care situation, respect for her right to make her own informed decisions, respect for her right to the best quality health care possible. PHCP honesty established a human-to-human bond that opened up the way for mutual sharing between the woman and the practitioner. Moreover, PHCP honesty indicated that the PHCP was not willing to risk the woman's health in the interests of himSelf (or herSelf). Instead of Self interest (e.g., pretending to have the knowledge or expertise, in order to preserve or promote

Self), the PHCP who was honest toward the patient was working to serve the best interests of the patient:

Louise: How do you feel about a doctor or a health care practitioner admitting that they don't know all the answers?

Jane: Mine does it all the time.

Amy: It makes me feel like you're a real person and you really care and you're a human being because I don't expect you to know everything, I expect you not to know everything and if you come across me like you know everything, warning bells start going off in my head thinking something is wrong. Because you shouldn't be like that because you are just a human being.

Jane: My story is that too, partly, with my GP he says "No I'm sorry I can't do this. Bye I'm ringing the hospital now – they'll see you there."

Melissa: I think somebody who admits they don't know what they're dealing with are going to go out and they are going to read and they are going to find out how they are going to deal with you - somebody that sits there and makes believe they know what they're dealing with is going to fuddle on and probably treat you wrong because they don't know what they are dealing with, they're not willing to admit it and they won't look up and read up about it.

Amy: I think there is an element of fear in there because if you're coming across like this then may be you really don't know and you're putting on an act and you could actually make it worse.

Jane: You can trust honesty - you can't trust dishonesty. And that's one of the big things with my GP.

Louise: And so what are you risking when your practitioner is being dishonest?

Jane: Your life.

Melissa: Yeah.

Amy: Mmm.

Melissa: Or at least your health. (W#2:1002)

Theme 12: Empathy

Involvement with Detachment

'Empathy' is a term the women used often and confidently, to express the care response from PHCPs that they experienced as certain involvement by the practitioners that is, at the same time, characterised by a degree of emotional detachment. The women understood that the involvement enabled the PHCPs to identify with the patients, while the detachment ensured that they were able to relate without being "*crippled by their own emotional baggage*" (Melissa, W#5:2141).

Professional Caring

These participants thus regarded empathy as a distinctive type of professional caring – in this context a connection between the patient and the practitioner that was professionally tempered by restraint. The empathetic connection afforded the practitioner a full understanding of the patient's health care reality. The restraint afforded the practitioner the emotional distance and hence the objectivity necessary to make sound contributions as the health care provider.

Empathy, as a PHCP care response, was perceived in physical behaviours as well as non-physical qualities. The women variously saw it and sensed it in their health care practitioners. For example, during the following discussion the women collectively interpreted as empathy the PHCP's subtle shifting of position within the physical space of the encounter:

Louise: That empathy thing though... for Louise the empathy began with this [shifts chair forward].

Melissa: Because that is a very caring gesture..."I've moved out of my personal space and now I want you to move out of yours."

(All talking.)

Amy: ...like having the consultation with the registrar at my feet [of a hospital bed] but then moving up to my head, so not talking to me from the space down here but coming up here and explaining "This is the situation." (W#5:1673)

In contrast, in Melissa's emergency experience with her son the central health care practitioner remained behind the desk, physically separated from them:

...it is late in the evening (10 p.m.) when they hit the emergency room. They are seen by the triage nurse who sends them down to the kids' area to wait to see the doctor. And wait and wait and wait. It is now one o'clock in the morning and Melissa feels she has been very patient. In fact, if it was not for the child's pain she would have walked out hours ago. She understands that the doctors are busy and will get to them when they are free. But this does not explain the fact that the nurses have been sitting at the nurses' station for around two hours now with only two other patients in the area, and nobody has bothered to speak to them or check on the boy's condition.

Melissa walks up to the nurse sitting behind a desk and asks when they can expect to be seen by the doctor. She is informed that they are busy and if she wanted to be seen right away she shouldn't have come to the ER this late at night when they were short of staff. Melissa informs the nurse that she had returned because the doctor had instructed them to return. The nurse then tells Melissa that she should have got there before 9 p.m. when there were more doctors around, at which point Melissa points out that if the child had been in pain before 9pm she would have been there before then.

Melissa then informs the offending person that they had been waiting for three hours, and asked could something be done about her son's pain. She is informed "I don't know what your problem is. Some of these people have been waiting for over five hours." On being informed that that bit of information did not help the boy, this person then looks over at Melissa's son, who is sitting about 50 feet from where they are standing, and states: "He doesn't look too bad to me. He can wait a while longer." She then walks out of the unit.

Melissa picks up her in-pain child and walks out. Commenting as she left to all who care to listen: "Don't worry about us we'll go and find somebody who cares" and leaves for the private emergency clinic down in town. Where the doctors may not be familiar with her son's history but at least they care enough to treat his pain. (W#4:32)

It was evident from the women's work that their individual experiences of empathy also comprised PHCP care-responses that were individual-specific, according to such factors as the nature of the health concern and the woman's needs at that particular time. Gentleness (e.g., Emma), attentiveness (e.g., Jane), reliability (e.g., Jane, Melissa), and nurturance (e.g., Melissa) are examples of PHCP care-responses that figured in the narratives of individual women and subsequently were discussed by the group but did not emerge as common to the experience of empathy, and hence trust, for this group of women. These various care-responses are testament though to just how attuned the trusted PHCPs were to each woman, and to their ability to respond to personal needs in their delivery of individualised health care.

Compassion

When the women were facing a serious health concern or were in a health crisis, then their individual and collective work profiled trusted PHCPs who showed them compassion, rather than a simple empathy. Their understandings of empathy and compassion indicate that in their experience compassion is a 'higher-order' form of empathy, rather than a separate construct. In their positive trust experiences, the women's PHCPs moved beyond the deep comprehension of their health concerns that distinguished empathy, to a genuine desire to do whatever they could to relieve the patients' distress.

Thus, compassion involved the same identification with the women that empathy requires, but allowed for more feeling in the PHCPS' response to patient suffering. Jane's midwife exemplifies compassion in her response to Jane's suffering towards the end of her third pregnancy. Constance, the midwife, moved to spare Jane from further suffering and arranged for Jane to be induced two weeks early. To do this, Constance has had to defy established pregnancy management and flout standard protocols for hospital admittance.

6.5 Patient and Primary Health Care Practitioner

Together as 'They'

In the relational heuristic, 'They' refers to the relationship itself, the phenomenon created by the interaction between the woman and the PHCP. Following Gestalt psychology, this relationship is different and/or greater than the sum of its separate parts: the woman and the PHCP. This section explores that domain of the participants' experiences of trust (both positive and negative) that they perceived and made sense of as an expression or dimension of the relationship as a whole. Included in this section then are those dimensions of their trust experiences that the women lived as a characteristic or a dynamic of the patient-practitioner relationship itself, and the implications of the relationship phenomenon for her as an individual. The women developed three themes to describe their trust as it related to They the relationship: Safety, Reciprocity, and Empowerment.

Theme 13: Reciprocity

In their experiences (positive and negative), these women found that trust set up characteristic dynamics within the patient-practitioner relationship. The dynamics that emerged from their positive trust experiences constitute the theme of Reciprocity, or the 'give-and-take' movement that occurs between the women and the PHCPs. This theme makes sense of the relational rhythms of action, influence, response, and communication perceived by the participants.

Trust

The women found that in their positive relationships, trust itself was reciprocal. The practitioners whom the women trusted, trusted them the patients. Most common in their work on trust's reciprocity were stories and discussion concerning their experiences of PHCPs trusting the women's innate feelings about their own health or the health of their children. Previously cited examples of the practitioner trusting the patient's 'insider information' include Jane's midwife who trusted Jane's desperate assessment of just how precarious her well-being was (W#1:p.20), and Melissa's GP who trusted her gut feeling that something was seriously wrong with her son's knee (W#2:663). These experiences of reciprocated trust commonly were theorised as follows:

Louise: I go to him [the chiropractor] now when I physically need to...I guess I'm going with the "OK. Here's the problem, deal to it" approach....I go to him for symptomatic relief.
Melissa: So once again, it's a knowledge thing - you know what you want when you go to him.

Louise: Absolutely. And he's OK about that...He's happy for me to come when I need to, knowing when I need it.

Melissa: He trusts you to know when you need it. (W#2:2196; also, see W#2:2785).

Indeed, Jane reciprocated her GP's trust in her innate knowledge of her state of health, by trusting that, at times, he knew her better than she did: *"Much as she did not want to comply, Jane had to trust his knowledge of her body and the way it worked"* (W#2:2537).

When PHCPs did not reciprocate their trust, these women lived it as a major source of distress in their experiences of betrayal, dismissal, disbelief, and bullying by those practitioners. Non-reciprocity could set up its own negative dynamics within the relationship; when these women perceived that the PHCP was not honouring their trust by trusting them, then the women lowered their trust in the practitioner, some times severing the relationship altogether (e.g., Louise did not go back to the dentist who had been "so dismissive" of her, W#4:2662).

Honesty

Just as the women trusted their PHCPs to be honest with them, so the women perceived that these practitioners trusted in their honesty. They interpreted the PHCPs unconditional belief as demonstration of their trust in the women's truthfulness: *"Yes, it's like the health care practitioner trust us as the client or the patient that we're not giving them some cock-and-bull story. They trust us..."* (Amy, W#: 843). Amy's optician trusted in her honesty at a different level when he trusted that she would return the *"whole little bag"* of optical aids he gave her to take home and test out.

One of the most remarkable things about the participants' stories and interpretations of PHCP trust in them as patients was the feeling of surprise that accompanied these

expressions. Evident in the last phrase of Amy's comment above, for instance, this surprise was a feature of the women's sense-making of this aspect of the trust phenomenon. The collective feeling of 'Wow, they trust us' can be understood as a reflection of the delight the women felt as customers when they were trusted by the health care providers; in other words, an indication of how low their expectations were going into such encounters.

Respect

Respect emerged as an integral aspect of trust as the participants explored the notion of reciprocity within the relationship as a whole. The women allowed for the humanness of the PHCPs in those relationships where they felt as though they were being respected as persons. Both the woman and the PHCP could be human in these relationships; each respecting the other's state of health or life circumstances for instance, and also taking into account the particular contextual constraints the other might be experiencing in any one encounter (e.g., time constraints, limited access to knowledge or experience).

The women's respect for their PHCPs was often demonstrated in the relational response they coined 'forgiveness', or making allowances for them when they were late (e.g., W#4:555), unable to answer questions (e.g., W#2:1002), forgot details of an individual's health care history (e.g., W#2:625), were not involved in the interaction (e.g., W#4:557), or were simply having one of their "*bad days*" (W#2:591). At more of a professional level, this respect was also demonstrated in the women respecting the practitioners' decisions when they were not absolutely sure that these were the

'right' judgement calls to be making. The patients were respecting the practitioners' expertise and competence at these times (e.g., Melissa and Jane with their GPs, W#2:1172; Louise with her midwife, W#1:p.26).

Partnership

The women linked the notion of reciprocity of trust to health care interactions that they experienced as joint teamwork, or partnership. Together, the patient and the practitioner melded into a team, and that conjoined unit focussed on the woman's health care problems. Within these interactions the women understood that they and the PHCPs were working side by side on the same plane, merged together in a non-competitive horizontal relationship as opposed to a hierarchical vertical relationship. These cooperative partnerships generated the shared decision-making (W#2:47) and shared health care responsibilities so valued by the women.

Theme 14: Safety

Trust was experienced by these women as an individual's sense of personal safety within the relationship. The relationship was, in the broadest sense of the word, a secure place for them to be, a relational place in which they experienced this sense of 'safety': *"I feel totally and completely and utterly safe. Like I'm going to be protected [by her GP]. Nothing bad is going to happen. And that's just the way it is"* (Jane, W#5:2205). The women's general expressions of safety commonly conveyed the feeling of being safe from danger. This freedom from danger enabled the women to feel secure and protected.

However, beneath this general expression of 'safety' was a range of nuanced meanings, subtle expressions of the individual's perception of the risks inherent in any specific health care context.

Jane's interpretation of relationship 'safety' referred to being sure that she was not in any danger from the PHCP, that he was competent and she was not at physical risk. She was sure that her body was safe with him (W#5:2200). This construction thus comprised a trust that the PHCP had the technical skills and ability to deal with her health concern.

Melissa's 'safety' included a confidence that the PHCP would not get hooked up emotionally in the patient's situation; instead, the practitioner had been trained to remain professionally detached in order to discern the Big Picture for the patient, and deliver the appropriate health care (W#5:2139). The risks implied in this interpretation include incorrect assessment, misdiagnosis, and wrongful treatment.

Several of the participants recounted feeling unsafe in themselves, both physically and emotionally. Both Jane and Louise experienced health situations when they felt as though their bodies were letting them down bio-mechanically, and all of the women had felt at one time as though their emotions and thinking were out of control and therefore 'unsafe'. At these times, in their positive patient-practitioner relationships, a sense of safety was re-established because the women trusted that the PHCPs would do whatever was needed to help restore their well-being.

Two of the participants lived the sense of safety in relation to their domestic partners. They felt unsafe talking to their partners about their health concerns because of the repercussions at home. But within the health care relationship both were felt able to speak freely to the practitioner, living the relationship as a place of refuge and protection.

Security

Finally, it must be noted that each of the women detailed instances where she had experienced safety as a secure environment in which she could interact without fear of being injured by the PHCP at an emotional or Soul level. The trusted PHCP did not judge her (e.g., Emma, W#5:1607), dismiss her (e.g., Louise, W#5:965), diminish her feelings (e.g., Amy, W#1:101), or disregard her (e.g., Melissa's narrative, W#4:12). In the security of their trust relationships, these women felt safe to ask questions (Melissa, W#2:658), safe to express emotions (e.g., Emma, W#2:1398), safe to raise issues (e.g., Jane, W#2:3014), and safe to challenge or oppose PHCP recommendations (e.g., Louise's narrative, W#1:p.26). Her sense of Self, the well-being of her Soul was not at risk.

In the safety of their relationships with their trusted PHCPs, these participants felt able to disclose their thoughts and feelings about their health concerns. The relationship did not constrain her or put her at risk; there was room for the woman to move as together she and the PHCP adapted to the particulars of her health care situation, and worked to find the 'best' responses between them. The relationship created a relational climate in which the woman felt safe. The conditions of the

relationship itself preserved her belief in herself and fostered her belief in the practitioner. These facilitative conditions were inextricably linked to each of the preceding themes explored within the relational heuristic; for example, the women's need for affirmation, and the PHCPs' unconditional acceptance of their female patients. Together, the patient and the practitioner created a relationship that was essentially non-threatening to the woman. From the place of security engendered by these conditions, these participants were able to trust.

Theme 15: Empowerment

'Empowerment' is the third theme that the women developed to describe their trust as it related to the patient-practitioner relationship as a whole, the They of the relationship heuristic. The theme, as applied to their health care contexts, was constructed by these participants around such topics as safety, self-confidence, conscious choice, control and responsibility, active participation, power and powerlessness, reflection and change. They conceived of empowerment as a particular state or way of Being-in-relationship, that they, the women, could reach and maintain within the patient-practitioner interaction.

This empowerment enabled these women to live their health care encounters with a sense of personal power and control. In the participants' common-sense of 'empowerment' it was also understood as a personally significant product, or outcome, of those health care relationships in which they had their positive experiences of trust. In this sense, then, the empowerment experienced by the

individual women was a natural by-product of trust, conceived and nurtured within the relationship itself.

The common plot-line to the empowerment experiences of this group of women was simple: each woman felt empowered, as a consequence of being in a positive trust relationship with a specific practitioner, to take more control of her health care. From the safety of the relationship, she was able to confront both the reality of her health care situation and the fears with which she had wrapped it:

Louise: One of the special things about this doctor was that he seemed not ever to take control from you and do it for you.

Emma: Yes. It's almost like a consultative process. Like we're thrashing out the decisions together.

Amy: Like teamwork.

Emma: Yes. It was like "How about this? Is this OK with you?" and I think about it and go "Yeah, that's OK. I like it – we'll try that."

Jane: By the time you had got to the stage where he'd said "Yes, there is a problem" and "Yes, it's got a name", "Yes, it's treatable", over the course of the consultation did that put you into a place where, when you first went in you were out of it, and by the end of the time you were able to make decisions?

Emma: Yes. In the space of an hour.

Louise: It's a huge turnaround.

Emma: Yes it was. Going from being a blubbering mess... reliving the anxiety and the stress and the fear.

Louise: The fear about...?

Amy: "You're going mad"?

Emma: Yeah. "I'm a crazy chick" kind of thing, and "I'm going to be locked up in a mental asylum with a straitjacket on"....it's a hard thing for me to describe. But I just felt that by the time I walked out of there [GP's room] it was as though – even though it was 'out there' – I couldn't turn back from it

anymore and it was going to be OK. (W#5:2436) Also, see W#5:449, collective work on Louise's narrative.

Following the collective plot-line, the woman was enabled to take considered steps toward managing her well-being, empowered with knowledge and growing self-confidence, secure in the safety of the relationship with the PHCP. For example, the woman's resolve, active participation, and deliberate movement forward were expressed in Emma's description of her thoughts after she had chosen to confide in her GP: *I've dumped my baggage on the [GP's] table and it's out there and it's done. And now we're in the phase of moving on and figuring out what we're going to do about it (W#5:2237).*

The empowerment generated by the relationship had different impacts according to the individual and her health care situation. The group endorsed Louise's experience of feeling empowered to trust herself again, and the impact such empowerment had on her general self-confidence, following her entrusting her GP with the domestic violence details. Group discussion also revealed that this self-trust empowerment had important implications for the women's consumption of health care services: women who felt empowered to trust their intuitive ways of knowing about health felt confident seeking professional help sooner:

*Melissa: Because you'll go and see him as soon as the symptoms [of sinusitis] arise because you know that it is real.
Jane: Yes – it's that empowerment (W#5:2770).*

Other participants lived empowerment within the patient-relationship as a realisation that, at a particular point in time after reflection, they had consciously chosen to alter their 'habitual' patient response or behaviour in the health care context (e.g., Emma determining to be as informed as possible about personal health conditions,

W#3:1102; 1114). Such purposeful change followed negative health care encounters, when the women had re-evaluated their characteristic ways of coping with health care situations where they found they were acquiescing to a stereotypical role of submission, and subsequently putting themselves more at risk.

In these instances the women began by questioning their acceptance of the traditional practitioner-patient roles, and basically, claimed their power themselves:

Louise: [Crying] And in the time since, one of the things I have been determined to do is understand it [domestic violence] as well and as quickly as I can, so that I don't waste any time, - you know, like that was a whole hunk of time that was really, really shitty. I don't want to go there again. I've got to understand what went on, almost as a defence to prevent me from going there again.

Emma: It is like a knowledge thing.

Louise: Yes. It is. And it is like I don't want the quality of my life or the quality of my children's lives compromised by ignorance.

Emma: Yes. I feel that too. Being abused, I know for the future that I will never let my children get into a position that I was in. I don't want them to. I want them to have more knowledge than I had.

Jane: And that's part...well, what the primary health practitioner, midwife and GP did for me. They empower you with the knowledge that you need. (W#5:2739)

This (self-)empowerment was respected and enhanced in their positive experiences of trust with PHCPs, enabling them to take a more active role in determining their health care. In these ways then, the relationships of reciprocal practitioner-patient trust fostered, rather than quashed, the autonomy of these women.

Power

'Power' was not an issue per se in their non-competitive, non-hierarchical relationships, rather power was another resource within the relationships that was to be shared and exercised responsibly in the interests of the women's well-being. The women did not have to wrest their power from the Other, they merely had to recognise that their power was theirs by right and always there for them to use.

Across the group, the empowerment experienced in the health care relationship had important ripple effects. Empowerment grew from the courage to deal with a specific health issue to a sense of efficacy and control in other areas in their lives in general. Moreover, as these women learned to relate and live 'in power', they were aware that they became teachers and role models for Significant Others, such as their children, mothers, sisters, cousins, and friends (W#3:1175; 2415; W#4, 2186).

6.6 Concluding Comments

Trust was experienced by these women as a vital, dynamic phenomenon, created by both the patient and the practitioner in relationship. The relational heuristic device, which emerged from their work, has enabled us to deconstruct their trust experiences within the context of the patient-practitioner relationship itself. While this has resulted in the three separate domains of 'She', 'Other', and 'They', and a number of clear themes and thematic aspects which have made sense of the women's trust at those

levels, at the same time the relational heuristic itself underscores the relativity of the trust phenomenon. The heuristic provides an ideal analytical framework for understanding the relational and social nature of the trust themes in each domain. Each theme is a common and distinctive pattern of trust that nonetheless remains always an integral part of the whole – the relationship between the woman and the PHCP. The trust themes we pull out to explore separately rely for their fullest expression and meaning on their place in the fabric of relationship. This heuristic keeps the fabric intact.

The women of this research used 15 themes to help them make sense of patient trust. Four of these themes related to the woman as patient in the 'She' domain of the relational heuristic, eight related to the PHCP as 'Other', and three of their themes focussed on the relationship between patient and practitioner in the 'They' domain. These themes and the important constituent aspects of those themes are summarised here in Table 1: Themes and Aspects of Trust in the Women's Experiences. This table summarises the main themes (numbered to correspond to their notation in the text of this chapter) and their constituent elements referred to as 'Aspects', relative to the relational domains used in the data analysis.

The next chapter examines the men's experiences of trust in PHCPs, and the ways they make sense of that trust. Again, the chapter will be focussed on the men's own descriptions of their trust and the themes they employed to make sense of their trust experiences. Chapter 8 will examine the similarities and differences between the trust themes used by these women and men, and develop the theoretical links between gender and those experiential themes.

Table 1: Themes and Aspects of Trust in the Women’s Experiences

Domain		Theme	Aspects
Patient as ‘She’		1. Vulnerability 2. Knowledge 3. Affirmation 4. Voice	Perceived risk Fear Power Sense of Self Personal Acknowledgement Validation Individualised care Self-expression Silence Dialogue With-holding truth
PHCP as ‘Other’	Cure	5. Clinical Skills 6. Responsiveness 7. Professional Confidence 8. Thoroughness	Accuracy Appropriate treatment Willingness Speed Assurance Authority Patient’s health context
	Care	9. Acceptance 10. Personal Connection 11. Honesty 12. Empathy	Unconditionality Impartiality Patient’s life context Patient’s best interests Listening skills PHCP intuition Prognosis Respect Involvement Emotional detachment Professional caring Compassion
Patient & PHCP as ‘They’		13. Reciprocity 14. Safety 15. Empowerment	Trust Honesty Respect Partnership Security Control Self-management Power

6.7 In My Own Words

Sunday 29 Dec, 2002: An interesting chapter this. Have wrestled with some big issues for me as a researcher – learning mainly to learn to listen to the women's voices and stories, and grant them the respect that I have been espousing from the beginning – learning to respect and celebrate difference in our experiences. Also, to have faith that if I can sit still and silently for long enough then I will be able to discern the best way to re-present the work. Having faith in the rightness of the women's work, and the ways that they understood their trust, and having the courage to let go of the framework that I had dragged with me into the research and experience the Big Empty Space that existed in its place for a couple of days while I worked at waiting to discern the Women's Way.

Am recognising patterns of work for me and learning not to be afraid. Seem to work to a rhythm that spikes on chaos and clarity. Will work up toward a state of confusion and grope around in that for several days, succumbing to panic and despair at times, but am learning that like an athlete I can persevere and my brain will find a way to deal with the confusion – some typology or order – to reduce the cognitive distress that the confusion has caused. This new understanding seems to signal the edge of a new plateau, which I then traverse until I hit the wall that marks its end, and once again work to find my way above the wall of confusion to explore the next plateau.

Am also interested to observe that this chapter has marked a transition in the focus of my reflections. As I work with the collective's narratives and discussions, then my reflections have been focussed on the groups' sense-making, rather than on the

processes I have been engaged in as an individual. Same energy and effort – different focus. Less personal introspection, more rolling around in the riches created/amassed by the groups.

Have been surprised by sudden moments of understanding about myself and my personal relationships that have happened along the way. In recognising loyalty as a theme in the women's trust experiences, for instance, I have come to understand much more clearly its significance in my own relationships and personal history. Am grateful for these understandings and the knowledge that they afford me in being more conscious of how I can choose to deepen my relationships with the people in my own life.

At a more general level have become aware that there are many similarities between the relationships that the women describe with their primary health care practitioners and our most intimate personal relationships. While this awareness allows us to extend our understanding of the dynamics of the professional relationship in the health care context, it also brings concerns about relational behaviour that so often occurs within the patient-practitioner relationship which is regarded uncategorically as abusive and violent within domestic relationships. Why is this? Is the practitioner more protected than the domestic perpetrator? Is the patient less 'sacred', afforded even less dignity than the partner trying to live in a context of domestic violence? Why do we tolerate the same abusive behaviour from practitioners that can lead to police protection, compulsory counseling, and prison for perpetrators in the domestic context? Sobering thoughts. Why do patients remain in unhealthy professional

relationships? How are the reasons similar/dissimilar to those that keep partners in unhealthy domestic relationships?

Went to a party last night, many of the guests were medical people – an anaesthetist, three GPs, one ear, nose and throat specialist, and one psychologist. Found myself bristling as I listened to an exchange between the anaesthetist and psychologist about how birthing has changed since the midwives have become the main health caregivers at births (only 2 GPs left here who practise obstetrics).

The two men were indignant that neither the women giving birth nor the midwife wanted them in the room – “we’re just not welcome – need an invitation these days to get through the door.” Thought about it all a lot this morning and it took me back to the conversations I have heard throughout the years in which patients (and it seems to be female patients more often than males) are dismissed and diminished in the private talk of health care practitioners.

My whole project was sparked partly by the horror at this talk, at a time when I was keenly aware of the damage that can be suffered at the Soul level within a relationship that is intimate and trusting. Recognised then, albeit subconsciously I suspect (didn't realise it at the time!), that the health care relationship has strong similarities with domestic relationships, and that many of my experiences with health care practitioners paralleled those in the personal relationships of my private life. And that the way these practitioners were talking and regarding their patients, that their patients were type-cast for disrespect and likely to be experiencing “abusive” relationships from their health care providers.

Was very conscious at the time of the injustice of abuse and the basic human right of every person for equal dignity and respect from any other human, despite differences in race, culture, religion, age, wealth, education and gender. Once I began to wonder if some PHCPs might not be extending this fundamental human right to all their patients, the germ of the research was sown – how do patients experience trust in their relationships with PHCPs?

Theoretical Reflections

Deep trust can be understood as a dialogue between 'inner voices'. Experiences of vulnerability and/or betrayal can be accompanied by the woman feeling furiously critical of her own stupidity or naivete. Reviewing the encounter afterwards, many of the participants report ignoring their own initial perceptions that the encounter was wrong somehow. A fear of ridicule or embarrassment that kept them silent. Anger and amazement at these behaviours often follow health care incidents when the patient has disregarded their own 'inner voice'. Traditional patient and female socialisation virtually ensures that the patient will be poorly prepared for defending themselves from attack (physical, emotional, or spiritual) or protecting themselves from betrayal.

Context: Recognise that two of these women are using hospital emergency departments as primary health care providers. The hospitals don't like this but at times when their GPs are not available, or they don't have a relationship with a GP, or are financially impoverished, then these women regard and use the emergency department as a means of accessing primary health care. Will be interested to see how the men define the 'context' of primary health care provision.

7: The Men's Experiences of Trust

“...it was the start of the healing process to have found someone he trusted.”

(Dave, M#3:2526)

7.1 Introduction

This chapter needs to be prefaced by a short discussion about car repairs. Not Do-It-Yourself home car repairs but those that involve a man taking his car to a mechanic to be repaired. This is the metaphor that the men participating in this research used to make sense of and communicate how they experienced health care. According to this metaphor the man (representing the customer/patient) takes his car (his well-being, state of health) along to the mechanic (the service provider/practitioner) to be fixed or repaired (cured).

To begin, before he takes the car to the mechanic, the man has usually waited some time to see if the problem will right itself. By the end of this period of time, if the problem has not gone away, the man will likely have formed some fairly firm ideas of what is wrong with the car, and will also have decided that he cannot fix the problem himself. Usually, initial contact with the mechanic will include the man saying something like: “My car needs to have the brake pads replaced.” Following the basic form of the car Metaphor, once the man is happy that the mechanic can fix the problem the man leaves the car with him. He expects prompt service at a reasonable charge. The man returns to pick up the car when the problem has been fixed – within a reasonable time and at a reasonable charge.

The men extended and elaborated the Car Metaphor to account for more complicated situations. For instance, those occasions when the man and the mechanic spend more time discussing the problem, the man telling the mechanic what he has ascertained about the changes in the car's performance, and special conditions or idiosyncrasies of the car which need to be taken into consideration. After the mechanic has outlined the repair options, and they have finalised the repair plan (including time, and charges), the man then leaves the car to be repaired. Reference to the metaphor affords insights to such complex aspects of the men's health care experiences as their self-diagnosis, their need for a healthcare 'fix', their detached attitude to personal health problems, and disembodied reaction to health crises.

The Car Metaphor appeared during the men's first Memory Work session and they continued to employ it regularly throughout the remaining four sessions. This was clearly the preferred, dominant metaphor employed by these men – the men knew the metaphor well (both the basic form and variations), apparently found it easy to use, and used it with obvious pleasure. It was used to frame individuals' understanding, but also enabled the men to share their stories and to recognise the common aspects of their health care experiences. Along with the metaphor proper, the men also used various car-related words throughout their research work, e.g., "steering" (M#4:3083), "backfiring" (M#5:2149), "fine-tuned" (M#5:343), "kickstarted" (M#4:2244), along with numerous (17) references to the "mechanics" of health conditions and their treatment (e.g., M#3:837, M#2:994).

In a narrative sense then, the Car Metaphor was a common plot-line to the stories, which the individual men used in particular encounters to make sense of their lived

health care. The metaphor also was a powerful way for the men to tell their health care experiences. In their use of the metaphor, the men provide us with a graphic backdrop for developing our understanding of how these men lived health care. This is not a new health care metaphor for males. It is well enough established within our culture to form the base for various health care promotions targeting men specifically. For example, a radio ad for the New Zealand Men's Clinic makes direct use of the metaphor: "A lot of people say you can tell how a bloke will perform in bed by the way he drives – but how many times have you arrived at work before pulling the car out of the garage?" (see Appendix J for full text and scheduling details).

There are interesting parallels between the metaphor and the mechanistic bio-medical health care paradigm, while at a psychosociological level the Car Metaphor can be understood to represent particular stereotypical male attributes such as agency, control, concern with money and things, goal orientation (in this context the focus on a 'fix'), and assertiveness (Heretick, 1981; Palmer & Bejou, 1995; Shifren & Bauserman, 1996). Both of these points, which help account for the metaphor's popularity with male patients, are expanded later in this chapter.

To examine the men's trust experiences I run the Car Metaphor of men's health care beside the relational heuristic developed in the previous chapter. Following the men's own use of it, I refer to the metaphor as a means of clarifying and deepening our exploration of their trust in primary health care practitioners (PHCPs), and checking that we remain 'on the right track'. From a methodological standpoint, because this was the key metaphor employed by the men to make sense of their health care encounters, it is appropriate that it help to frame the analysis and interpretation of

their work on patient trust. The metaphor appears in bold italics, at the beginning of various sections throughout the chapter.

Having discussed the backdrop commonly used by men for their health care experiences then, the rest of this chapter follows a similar structure to the previous chapter presenting the women's work, to both describe and explain how the men lived the phenomenon of patient trust within primary health care contexts. Thus, general points about the trust experiences of these participants and about their research work precede the detailed exploration and elaboration of their descriptions, perceptions, and constructions of patient trust.

These general points and observations are based largely on the men's collective narratives on trust, which they co-authored at the end of each Memory Work session. Relatively sophisticated, these collective re-presentations of a male patient's experience of trust in a PHCP were constructed when the men reviewed the group work that they had done over the preceding three hours, identified the shared aspects of their experiences, and integrated these into instalments or episodes of the collective grand narrative. Data in these next chapters that is based on this collective narrative is indicated by reference to the central archetypal character constructed by the group as 'The Man'.

Following this general overview of the men's work, the chapter moves into more detailed examination of their trust experiences. In order to understand the participants' experiences relative to the patient-practitioner relationship itself, I apply the relational heuristic device developed in the last chapter. Accordingly, their trust is de-

constructed into aspects that relate to three domains - the individual man, the practitioner, and the relationship as a whole.

Throughout the chapter, the text layers one man's narrative with another, individual narrative with collective analysis and interpretation, and (occasionally) the men's theorising with that of academic researchers and theorists. This chapter also marks the stage in the research when we can begin to examine any similarities and/or differences in the men and women's experiences of trust; these will be mentioned where appropriate in this chapter, to be discussed in more depth in Chapters 8 and 9. The underlying purpose tying together the sections of this chapter is to examine the men's trust from their perspective, focussing on the way they make sense of the phenomenon, and examining the interpretive frameworks of these men within the context of their knowledge and beliefs about patient-practitioner relationships.

The Men's Ways of Living 'Trust'

There were some interesting patterns across the experiences of these men before they had entered the consultation rooms, which related to their subsequent trust with practitioners. Word of mouth was very important in these lead-up patterns. Significant Other people, usually family members or other already-trusted health care practitioners, were prime sources of word of mouth recommendations for PHCPs. In addition, family members were often used by these men to check their perceptions of the practitioner, over the course of the patient-practitioner relationship. This check could be made either directly with the Significant Other, or indirectly, in a 'What-would-Dad/Mum/Wife/Partner-think-of-this-person?' mental exercise. These

Significant Others were people respected and trusted by these men, whom the men felt they were able to rely upon in matters of judgement.

The referral pattern was very similar across the experiences of these participants. Generally, having waited for some time for his health care problem to 'come right', the man discussed the problem with the Significant Other, who urged him to go for help to a specific practitioner. On the strength of this recommendation, lived as a sort of vicarious trust, the man went ahead and made an appointment with that PHCP. According to these men, they did not make any other inquiries beyond this recommendation – neither into other potential therapies or practitioners, nor about the specific practitioner. However, while the vicarious trust had been strong enough to support making an appointment, once the man had begun to physically move into the relationship himself (as a different, separate individual from the Significant Other) then he began the process of ascertaining the practitioner's trustworthiness for himself. In this way then, the vicarious trust was distinctly provisional in nature.

There are several plausible explanations for this word-of-mouth dynamic, all of which relate to the traditional masculine gender role. First, because it is difficult for many men in this culture to talk about their health concerns with others, according to the participants, they manage the anxiety around opening up to another by only doing it once. This reluctance to reveal their perceived weaknesses is evident, at the more general level, in their stereotypical reticence to talk to others about their health concerns.

Second, relying on only one referral speeds up the process of dealing with the problem. In other words, it is efficient, cutting down the time between voicing concern about a health problem (which could by this stage be quite serious in nature, given that they have even discussed it with another) and actually getting help from a health care practitioner. Gathering additional information or opinions takes time and effort – moving on the recommendation of one trusted source therefore saves time and is convenient. On top of either or both of these reasons, it is possible that the very realisation that they had to seek help triggered negative feelings about their own competence to handle the situation.

Certainly, while at times the men did articulate intense emotions around trust in their PHCPs, they presented their trust experiences overall as being predominantly rational, or cognitive, in nature. The reason(s) for this were not clear, although it is plausible that their apparent rationality follows traditional social conventions for males to be emotionally detached in health care contexts. These men tended to tell their experiences in short individual narratives (compared to the women's) that generally involved only the individual man and the practitioner. Their discussions were usually matter of fact and to the point, managed by the group around the underlying purpose of meeting the data requirements for this research.

As the PhD candidate, well brought up in a positivist culture, I relished the tidiness of the data that the men produced. It tended to exist in the transcripts as discrete chunks that were easy to label and shift into the appropriate compartments for analysis. However, although writing up the men's data was quicker than writing the women's

data, I found that without the comparative complicated 'messiness' of the women's data the process seemed, at times, more mechanistic and flat somehow.

This group of men also differentiated clear-cut 'types' of trust in the health care context, which corresponded with several forms theorised by scholars in the literature (see "Bases of Trust" in Chapter 3: Concepts and Connections). Recognisable in their work were instances of competence-based trust (e.g., Dave's trust in the competence of a dentist, M#5:385), profession-based trust (e.g., Collective, M#5:2633), and individual-based trust (e.g., Participant R.'s trust in alternative therapist Jan, M#1:1903). Their experiences also revealed a trust lived by these men in the context of primary health care that was based on a particular therapy and/or philosophy of well-being (e.g., Participant R.'s trust in Tinnitus Retraining Therapy, M#5:362). These trust types were not as clearly discernible in the women's trust experiences.

The participants clearly understood some of their health care encounters and/or patient trust experiences were "quick and dirty" (R., M#2:1963) by nature, because the problem was largely physical and required a straightforward mechanical fix. Or, to use their metaphor, the car had a mechanical fault and the mechanic had the tools (expertise and/or equipment) to repair it. Then these men described lived trust that closely matched the competence-based trust developed by theorists, in which the person's trust depended largely on the service provider's competence, or to use participant R.'s words, "whether she[he] was actually any good at the job" (M#4:2573); "the [PHCP's] ability to do the job" (M#4:290). At those times the men wanted a fix, not a deep and meaningful relationship, and their trust reflected their sense of occasion.

Outside of those relatively low-risk – sutures and standard antibiotics - health care occasions though, competence alone was not enough to build and/or sustain patient trust. In situations of higher perceived risk when the health problem was lived as more complex, more involving, or more consequential (16 of the 20 individual narratives described more complex health care situations), the men's data indicated that they wanted a different type of trust with PHCPs.

This trust, which R. called a “higher order of trust” (M#5:2568), was more complex, more involving, and more consequential for the men as patients. It was this latter type of trust that the collective seemed to value most in their patient-practitioner relationships, and put their effort into describing and understanding. The representation of the men's work in this and the next two chapters takes their lead and explores mainly those trust experiences that were more relationally complex. Following the men's observations that this higher order of trust occurred within the context of a personal relationship with the PHCP, as opposed to a ‘quick and dirty’ consultation, I also refer to it as relational trust.

Finally, it is interesting that these men wrote twice as many horror stories about trust as they did narratives about positive trust experiences. While the negative experiences must be regarded as important in their own right, by reflecting one through the other they can also lead to a fuller unveiling of what constituted trust for these participants. Therefore, as the men did throughout their work, this chapter refers to both their negative and positive experiences of trust, in order to illuminate the subtle contours of the trust phenomenon as they lived it.

7.2 The Relational Heuristic Device

The relational heuristic device allows us to grasp both the individual and the social aspects of trust that were experienced within the relationship between these male patients and their PHCPs. Thus it simultaneously frames the aspects of the man's trust experience that relate to him as an individual, and those that centre on the practitioner as the other individual, in the relationship that their interaction creates. In the context of this research then, the male patient is the He, the PHCP is the Other, and in relationship they create the They of the framework.

The heuristic, embedded in the women's work, was methodologically easy to apply to the women's data - the fit between the two was natural and productive. My first attempts to use the heuristic with the men's data were outstandingly unsuccessful - to my dismay and embarrassment (I had been convinced that the framework represented a 'methodological contribution' of some import that could be applied to any dyadic relationship). However, by consciously endeavoring to stop comparing the applications (men's with women's) and returning to the men's own ways of making sense of their trust experiences, I found that the heuristic also provided a valuable framework for de-constructing and extending the work of the male participants. The distinction was, of course, that the fit was different. Consequently, so were the results. The results, organised as themes that recurred across the men's trust experiences, are presented in the following sections according to the He (Patient), Other (PHCP), and They (Patient and PHCP) domains of the relational heuristic.

7.3 The Male Patient as 'He'

Those aspects of the trust experience that were felt and/or focussed mostly on the individual man himself, which originated from the Self, were directed toward the Self, and were owned or claimed by the Self, make up the 'He' domain of the relational heuristic. The men engaged in this research created four themes to make sense of their patient trust at this internal individual level: Risk, Evidence, Autonomy, and Personal Connection.

Theme 1: Risk

In which The Man decides that today he has to organise to get his car to a garage. There's something very wrong with the engine. And this morning on the way to work, it was running really rough. Over the last couple of weekends he had a good look at the ignition system himself, read up about it (found a manual for his model on the shelves at the library, and also discovered a couple of excellent websites, in Australia of all places). He did the best he could – replaced the air filter and spark plugs, reset the ignition points. But truth be known it's a bit beyond him. It really needs someone who knows exactly what he's doing and who has the right tools on hand. He needs a mechanic who is experienced with this make of car, isn't going to rip him off – either by overcharging or doing (or claiming that he's done) unnecessary work. The Man asks around a bit. Then rings the mechanic his brother-in-law uses.

Risk, or more exactly, the men's perceptions of the risk inherent in the health care situation, was one of the defining themes of the men's trust experiences. The first

trigger topic composed by the men, “Risking a visit to an alternative practitioner”, explicitly underscored the salience of risk, particularly as it was perceived relative to PHCPs that these men situated outside the boundaries of bio-medical practice. In later individual narratives the men explored risk also in allopathic health care contexts, narrating a range of experiences which indicated considerable variety in their risk perceptions.

Financial Risk

Financial risk, or “whether they’re just after your money” (Dave, M#1:1852), was extremely prominent in the men’s trust work. This concept, well developed in marketing literature, was likewise well formed and easy to recognise within the men’s work. Financial risk, tagged “Ka-Ching” by Dave (M#4:117), was a constituent aspect of the bigger analysis category called ‘Money’. The participants referred to money more than 40 times (using a number of terms, e.g., ‘money’, ‘cash’) over the course of the research, a hit-rate that made Money numerically the biggest category in the men’s data analysis. Because the topic of money was threaded throughout their work, it appears in various places in this chapter, but is discussed most fully in the next theme, called Evidence.

Interestingly, these men did not discuss to any substantial depth their experiences of financial risk, perhaps because it is a well-understood consumer experience that can be communicated without difficulty or elaboration. This would help explain why the men as a group did not deconstruct their experiences and understandings of financial risk. However, there were strong clues throughout the men’s work that indicated

financial risk was, in fact, an important issue for them as health care consumers. First, the language they used on the topic typically conveyed strong emotions such as anger, outrage, indignation:

"...an extortionate rate..." (R., M#4:2086).

"Exorbitant amounts of money" (Jimmy, M#5:747)

"More money to the quacks" (Brent, M#1:637).

"Exiting with an empty wallet and a bottle of pills..." (Jimmy, M#2:510).

"All I represent really is another \$30... a meal ticket for the doctor" (R., M#2:1755, 1689).

"Jimmy's a person, not just another \$40 that walks out the door" (M#2:1001)

"I was in a real state. I didn't feel as though there was any slack at all in her very mercenary system for doing anything other than just continuing with the production line and making \$250 an hour. 'Thank you very much. Next!'" (R. M#4:1969)

"They're not [just] trying to grab my \$500 off me..." (Jimmy, M#5:2535)

"Had this just been a ploy to rip him off for an extra \$250 a session?" (R., M#4:1854).

Second, all of the men could quote precise amounts of money that they had been charged by PHCPs on different occasions (sometimes years ago) when they had felt exposed to financial risk. Conscious of the financial risk at a more general level, R. had also kept a running tally of how much he had spent in his 14-month search for help with tinnitus, spanning 35 practitioners. These clues to the importance of financial risk for these participants also pointed to psychological and social depths to the perceived risk: in their keenest experiences of financial risk invariably the men felt as though they had been "sucked in" (Jimmy, M#2:2184).

Performance Risk

Performance risk, or the danger that the PHCP's service will not be performed to the patient's satisfaction (Garner & Thompson, 1985), was lived by these men as yet another risk that the practitioner was out to "con" them (R., M#1:1073):

Dave:...another risk is that you're not really sure whether their qualifications are valid or not. You don't know whether the person is actually, 1. qualified at a good college or whether they've just got it over the Internet. Or whether, 2...

Brent: It's a bit like a second-hand car dealer.

Dave:...whether they fully understand the field that they specialise in. Or whether they're just after your money. (M#1:1846).

At times, performance risk was acute for these men in their negative experiences of trust. During the first visit to a new PHCP, these men commonly alleviated performance risk by looking for physical evidence, like professional certificates, that the practitioner was "legitimate" (R., M#1:1729). Further on in a patient-practitioner relationship, acute performance risk was often triggered by some PHCP behaviour or response perceived to be an indicator of untrustworthiness, and then fuelled by suspicion.

Social Risk

The men experienced mainly social or psychological risk in their relationships with alternative PHCPs. In services marketing theory, social risk is defined as "the risk that the selection of the [PHCP] will affect in a negative way the perception of other individuals about the consumer" (Garner & Thompson, 1985, p.150). The men

themselves understood social risk simply as “what other people would think”

(M#1:158). Brent, for instance, recounting a relationship he had with an osteopath/homeopath 20 years ago, identified the risk factor quite clearly as “his family finding out” (M#1:154):

Brent was really taking a risk going to this person in terms of his family's opinion about outside health care people...Brent never informed his own children for instance. No one even in his work place knew. His own children, who at that stage would have been teenagers, they never knew. So it was ever only his wife that knew. (M#1:61-72)

He was keenly aware that his decision to go to an alternative practitioner could have serious negative consequences if word got out that he was seeing one of “these quacks” (M#1:644). Ultimately, this perceived risk was so strong that Brent chose to stop seeing the practitioner rather than continue to expose himself to the risk of “possible mockery by his parents and parents-in-law” (M#1:23). He made this decision despite the fact that the practitioner was taking a holistic approach to Brent's problem, which was a new and satisfying health care experience for Brent at the time.

Brent and R. had to travel out of town into the country to consult alternative PHCPs. The men appreciated the symbolism of the journey from the mainstream into unfamiliar country, and were also aware that the physical location of these practitioners afforded them valuable privacy. There was little risk that anybody from their community would see them going to these “way out” (M#1:1351) practitioners, their visit to a wacky practitioner providing evidence of “some wacky [mental health] problem” (M#1:77) simply because the man was having to go outside the realms of medical practice.

Perceived risk could deepen over the course of the patient-practitioner relationship. For example, Brent's alternative health care treatment centred on cranial massage, which he found relaxing and indulgent at the same time. And thus, while it was a source of satisfaction, the treatment itself became another source of risk. Brent described enjoying the treatment as a type of pampering. But he also perceived it as being outside the norms at that time for male patients, a "womanly thing" (M#1:121), and thus more potential ammunition for the family to level against him if they found out about his questionable health care behaviour.

Psychological Risk

Although, as the men stressed, today there is less 'social stigma' attached to seeking help from an alternative PHCP, they continued to experience it as being psychologically risky. This type of perceived risk, which relates to the consumer's peace of mind, self-esteem, or self-image (Garner & Thompson, 1985), was reflected in the men's descriptions of the personal intellectual and emotional challenges that they faced when they consulted a PHCP who practised outside of their comfort zone.

These men made sense of one set of these challenges by reference to the common anxieties they experienced "going into the unknown" (M#1:1304). These unknowns were created commonly by lack of previous experience or by lack of knowledge about the alternative discourses used in these different health care contexts - the conventions such a consultation would follow, different treatment techniques, or a different way of relating to the patient.

Beyond these rather pragmatic unknowns affecting their self-confidence as patients, were concerns of a more esoteric nature. Dave introduced the concept of “intellectual integrity” (M#1:1897) to express a type of perceived risk that the men detailed when their personal integrity was threatened:

You feel as if you are putting your own integrity on the line by having to trust someone who often you're just going to by faith. [Having to trust] that this Bach flower remedy or this homeopathic medication is doing what they say it does. Even if it appears far-fetched (M#1:1897).

These men found it difficult to sustain trust when their intellectual integrity was at risk. At these times they felt as though they were being expected to believe in a treatment that was “way out”, “non-scientific” (R. M#1:1856), “beyond the realms of possibility” (Dave, M#1:1358) without any physiological proof of its efficacy.

In their negative experiences of trust, the participants often lived a challenge to their intellectual integrity as confirmation of the practitioner's quack-ness or incompetence, and hence as confirmation of the desperate, emotional, unbalanced state of mind they believed they must have been in to make the appointment in the first place. It was at this point that these men, reflecting on the vulnerability engendered by ‘flaky’ emotional health problems (Brent, M#1:1877), often had serious doubts about the intentions of the practitioner (R. M#1:1010), their own judgement (R. M#4:1860), and/or the sanity of anyone – patient or practitioner – involved in health care therapies that could not be rationalised (Dave, M#4:1381).

In their positive experiences of trust in a PHCP, the men perceived no risk to their intellectual integrity. These men were able to appreciate the holistic traditions of a range of health care practitioners whose philosophies they did not always understand

and whose treatments they could not always 'see' working. In certain situations then, these last two conditions described by the participants actually characterised deep trust between a male patient and his PHCP (e.g., M#1:954, M#5:491).

Brent provided a rich example of perceived psychological risk in his description of being afraid that the PHCP would confirm that he did in fact have a serious health problem, and that this problem was related to a mental illness that his father had. In circumstances like this then, the consequences of the risk would be severe, with major psychological implications for the patient and his family. Such a confirmation would, of course, challenge psychological coping strategies, like denial or minimisation of significant symptoms, which the patient had been using to make sense of his health. Brent feared that the PHCP would open up a can of worms that he did not want to know about. Jimmy also knew this psychological risk well. He had confronted it for years, consulting different PHCPs about symptoms that eventually confirmed he has a rare, debilitating muscle disease that his mother is suffering from.

Relational Risk

Separate from both social and psychological risk, but clearly connected, is a distinctive type of risk that these men experienced in their high-involvement health care encounters. This 'relational risk', which concerns the interaction between the patient and the practitioner, has not been discussed in the context of service provider-customer relationships in the marketing literature but was clearly articulated by several of these men. This risk occurs when the patient perceives a risk that relates directly to the relationship itself. For example, the relationship itself is endangered

(e.g., M#5:318), the relational quality of the interaction is under threat (e.g., M#5:154), or the patient has doubts that a potential relationship will develop satisfactorily and therefore he questions the soundness of 'investing' time and emotional energy into it at all (e.g., M#5:644).

The men also referred to relational risk in the collective analysis of Jimmy's sensitivity to physical cues in a new servicescape:

R.: It is interesting how in Jimmy's case..., in the absence of any other real information, with it being the first visit to a new GP, that those physical cues come through so strongly...even to the point of the colour in the waiting room.

Brent: Yeah.

Dave: Mmmm.

R.: I wonder to what extent that is symptomatic of a certain apprehensiveness that Jimmy has chosen the right doctor, or is going to be able to see a doctor that will end up becoming 'my doctor'.

Jimmy: Definitely is. To be honest. (M#2:889)

In his description of a first visit to a PHCP, Brent provided an affective nuance to the relational risk construct, detailing it as an "anxiety ... about going into the unknown of another human being. It's not like I'm going to a place where I'm going to be physically endangered. It's really just that I'm unsure of what's going to happen (M#1:1305)." There are interesting parallels between such a first visit to a practitioner and a blind date. The patient is going into a one-on-one relationship with an unknown Other who will get to know personal (intimate even) details about him, and whom the patient must assume has honorable intentions. The relational risk experienced by the patient is thus similar to the risk inherent in a blind date that the

individual will expose himself to another human being and their relational interaction will not be successful.

Comparisons between the patient-practitioner relationship and intimate personal relationships have been useful for relationship marketing theorists already (e.g., O'Malley & Tynan, 2000). The men's use of the notion of relational risk to make sense of certain health care experiences suggests that it could be insightful for marketing theorists to examine more closely the work that has been done on an individual's relational behaviour as a new intimate relationship is established, or how it might have been impacted by the dissolution of previous relationships. It is possible, for instance, that a patient with a history of unsuccessful health care relationships could become progressively wary about entering a new relationship, or particularly guarded in his relational behaviour with the practitioner.

The construct of relational risk was developed further by the participants in their discussions about those times when they felt as though they had to temper their relational behaviour in order to keep the relationship going. At these times the patients simply were not prepared to risk the relationship breaking down. Either the patient had tried a lot of other therapies with no success, and had pinned all his hope of a cure on this final practitioner, or there was only one practitioner available with the necessary knowledge, expertise, or skills. R. and Jimmy, both of whom had gone to numerous practitioners for help with ongoing health problems, were able to describe more fully this type of relational risk:

R: I can't afford for the relationship to be soured...he was the only person.

Brent: Yeah....You don't want to offend this person...

R.: That's exactly right.

Brent:...because he's the only guy that has this therapy...You can't walk down the road and just find another one if you fall out with him or her.

R.: That's exactly right. Yeah, that's exactly it.

Jimmy: R. would be feeling that he's gone to so many different people and so many different places that even if there was another [practitioner] next door, it would be just another hassle to go and build a relationship and find out about someone and then...

R.: Even just as you were talking about it sent a shiver down my back. I felt it right there. You are so right. That's it exactly. I was really at the point I just couldn't be asked, almost, to go and see someone else, because it was just like the same old thing again, to handle one more time.

Jimmy: It doesn't matter what therapy, whatever. Same stuff, different person. (M#5:318-654)

The last exchanges in this dialogue make a clear reference to relational risk that arose for these men when, at a time of personal health crisis, they were just plain worn down with repeatedly building relationships with PHCPs. Later on in their discussion R. described also the “total fear” he experienced around the risk that this relationship might collapse – and therefore that he would never get any relief from his tinnitus.

In his relationship with a dentist, Dave found that his inquiries about the treatment were interpreted by the dentist as a challenge and hence put the relational quality of their relationship at risk. When he sensed that the dentist had taken umbrage at his questions Dave chose to “retreat”, a decision which the other participants were able to identify with and elaborate upon:

R.: ...the last thing you want to do is piss your dentist off. I mean there was a real bigger reason for a retreat there...

Jimmy: Because he still had to trust this guy.

R.: The whole thing about being in the dentist's chair and completely...

Jimmy: ...at the mercy...

R.: ...at the mercy of this guy who is probably going to hurt you more than anybody else you're going to see. (M#4:1576-1592)

As the other participants understood so well, Dave perceived that in this instance relational risk had potentially painful implications for his oral health.

There was also an interesting ripple effect to relational risk, in that the possible breakdown of the relationship between the patient and the PHCP could cost the man relational quality in his relationship with the Significant Other who had made the recommendation originally. These men explored this ripple effect around R.'s unsuccessful visit to a Christian faith-healer (Peter), on the recommendation of another alternative PHCP named Jan whom he trusted implicitly:

Brent: I mean, R. is definitely disillusioned in Peter. And maybe in Jan as well. And perhaps that clouded the relationship?

R.: Yeah, you're right...it took something away from Jan (M#1:954).

R. Later recounted that his relationship with Jan broke down soon after this, and he chose to discontinue his treatment with her.

Physical Risk

Physical risk, as lived by the participants in their patient-practitioner relationships, was a bottom-line risk that ran through most of the men's narratives. The antithesis of the 'fix' at the heart of the health care service relationship, physical risk was another

aspect of their experiences that was implied, lived as a taken-for-granted aspect of the situation. The men acknowledged a range of physical risks they perceived in various health care circumstances, from loss of life to temporary increases in pain, but they did not explore or develop the construct as such. However, the relationship of Physical Risk to trust was communicated clearly in comments such as Brent's:

There never seemed to be a moment that Brent was fearful that he was going to lose his life with Dr Scott. If he'd thought he was going to lose his life at any point, it was way back at that time when he was still in the water and maybe at that moment also when – at accident and emergency – when they'd said "It's a collapsed lung – we've got to do something promptly here (M#3:1730).

Brent lived loss of life as the physical risk he perceived in the diving accident scenario, but which completely vanished when he found himself under the care of a practitioner whom he trusted deeply. Dave implied pain and/or dental problems as another form of physical risk, which he perceived in his encounter with a practitioner when patient-practitioner trust had been compromised by a question he had asked which the dentist interpreted as a personal challenge: "...the last thing you really want to do is piss your dentist off (Dave, M#4:140). Finally, a sense of general physical risk was implied in R.'s unease during a visit to faith-healer Peter, who had been recommended by another practitioner called Jan:

Peter was a big average sort of a man who looked like a farmer, in an old pullover and jeans. 'Not at all like a doctor,' R. thought to himself. 'Still, if Jan suggested he could help it was worth a go,' he kept on saying to himself as he was led to a room with a massage bed in the middle of it. For a moment, R. considered his safety in this most unusual of situations. 'As long as Jan said Peter was okay, surely he must be,' R. kept on thinking to himself (M#1:696).

Likewise, time risk was another construct that was evident in the men's work but not linked directly by them to their trust experiences. 'Time', as a more general construct,

was lived as a key facet of their trust experiences, but these men constructed strong links between Time and the PHCP's competence and efficiency (rather than with risk). These links will be explored in the next section of this chapter, Primary Health Care Practitioner as 'Other', in Theme 5: Clinical Skills, and Theme 6: Professionalism.

Calculating Risk

The perception of risk involved calculation by the patient – sometimes conscious, at other times subconscious – of the possible benefits and costs in the particular situation, a cognitive weighing up of the alternatives, as Brent related in his individual narrative about the social risk he perceived in consulting an alternative PHCP: “The fact that his wife had suggested such a visit did not outweigh the possible mockery by his parents and parents-in-law “(M#1:22). In this example, Brent calculated that the social and psychological costs he perceived he would pay outweighed the benefits contained in the personal recommendation from his wife as a trusted source of reliable information. In the example of relational risk involving Dave and the dentist, Dave chose, after deliberate consideration, to ‘retreat’ from the interface to avoid the possibility that the subsequent dental treatment would be more painful than it needed to be. The benefits of remaining silent outweighed the possible costs of asking more questions.

Vulnerability

One of the consequences for the patient of perceived risk was vulnerability. The men recognised the interconnections: “The risk is inexplicably related to your sense of vulnerability about the problem” (R. M#1:1827), and were able to describe and discuss their vulnerability. Certainly, at times, vulnerability triggered intense emotions. Dave, for example, recalled feeling very alone and vulnerable during an acute mental health crisis, seemingly abandoned by his father and berated by a judgmental family GP. His individual narrative included the following lines which stood as a poignant understatement of his affective state at the time: “At one point, Dr S. asked him ‘So, how do you feel now?’ At that moment, it dawned on Dave for the first time that he felt incredibly, and deeply, sad.” (M#3:188).

Participants tended to record their emotional responses to vulnerability in their individual narratives, but group discussion moved over such emotions fairly quickly. This pattern suggests that although these men were able to write about their emotions they were not comfortable discussing the affective dimension to their trust experiences with fellow participants. At one point in a group session R. used the evocative phrase “valley of despair” (M#4:2384) to communicate the emotions which he battled as he sought help with tinnitus, but group discussion stalled soon after:

R.: I mean, if you imagine the old sort of ‘valley of despair’, then I was probably pretty much close to the bottom of it at this point.

Brent: That’s an interesting reaction – ‘the valley of despair’.

R.: Mmm.

R.’s emotional response was ‘tabled’, remarked upon, and then left. The group did not explore the topic.

Generally, the men indicated that they lived vulnerability differently from the women in this research. The women tended to live vulnerability as an affective state within their trust experiences. The men seemed to understand their vulnerability less commonly as an affective state and more as a patient position they had found themselves in during a health care incident. This way of understanding vulnerability as relational position, communicated over the course of the research, was reflected in the following session byte, during discussion of the differences between alternative PHCPs and orthodox medical practitioners:

R.:...that sense of vulnerability because you're having to step outside what you feel comfortable with.

Dave: ...So it's a leap of faith and/in a risk-taking situation (M#1:1792).

In this example R. and Dave actually used language and images of physical positioning to construct the men's commonsense of vulnerability.

The salience of risk for these men reflected the degree of uncertainty and consequentiality that they can experience in the context of health care relationships. Under these conditions trust could become all the more important as a means of coping with the perceived risk that they provoke (e.g., Crutchfield, 2001; Mitchell, 1999; see also Chapter 3: Concepts and Connections for a full discussion). However, the work of these participants indicated often they found that even as the need for trust increased, it became all the more difficult to achieve. Then, the higher the involvement, the more uncertain or ambiguous the health care situation, and/or the more vulnerable the patient felt, the more wary and guarded he became. And less and less likely to trust.

Risk and Trust

Brent's individual narrative on his diving accident provided an ideal example of the connections between risk and trust. In it he juxtaposed his unsatisfactory treatment by a series of PHCPs with that of a doctor in whom he experienced deep relational trust. Perceived risk was implicit in his descriptions of the faceless practitioners who treated him early in the incident, for example, "the house surgeon who had finally read the x-ray and then urgently jammed the drain through Brent's left ribcage" (M#3:290). Psychological risk, which Brent lived as a sense of isolation, was conveyed throughout his individual narrative by sentences like: "The absence of a warm family member who could just relax and be supportive added to the circumstance of being dumped in a screened cubicle and monitored from afar" (M#3:293). In clear contrast was Dr Michael Scott, who had to decide whether or not to put Brent into a decompression chamber, a decision that could be fatal (ultimate physical risk) if Brent had suffered an air embolism during a period of unconsciousness underwater.

Now he was in the care of Dr Michael Scott, an expert in diving accidents and decompression issues.

Dr Scott greeted Brent with "Well what have we here? I need you to tell me about this accident and exactly what has happened to you today. Give me as many details as you can about yourself and the event, and what has happened since then. I need you to tell me everything, moment by moment as you remember it."

As Brent lay on the ambulance bed, flat on his back as he had been since being placed on the bed in the first hospital at about 4.30 p.m., he stared up at the bright fluorescent lights, trying to get an image of the clinic or office that he now found himself. The discomfort of his swimming togs, the Speedos, that he always wore under his wetsuit, added to the prone position and glare of the lights.

He talked away for a long time giving all the details he could recall. "It's the time between when you surfaced and signaled

for help and then struggled aboard the boat that we need to explore,” said Dr Scott. “That particular time seems to be missing. Is there any chance you could have lapsed into unconsciousness?”

“Perhaps,” Brent considered, “as it is unclear in my mind, unlike all the events both before and after. Events before are very vivid and I can remember Brian getting me out of my wetsuit and making me comfortable on the boat.”

“Well we need to be sure,” said Dr Scott, “If there is any chance that you had a period of unconsciousness then an embolism may have formed at that time and to put you into the decompression chamber with an embolism would be fatal.”

Brent and Dr Scott talked for what seemed like a very long time. Dr Scott also performed some ‘tests’ to check Brent’s cognitive functioning and co-ordination. The night drifted along with talking and testing, probing and checking, clarifying and considering. Dr Scott came and went.

Finally at 1a.m. Dr Scott said “Right I’ve seen and heard enough to conclude that the best option for you is not in the decompression chamber. I’ll get you into a ward and settle you into a bed. You will need to stay here for a few days so that I can monitor your recovery and keep an eye on the drain you have in your chest.”

Brent relaxed. This doctor had been thorough and personable. He had taken a long time but during that time he had carefully monitored his progress and condition. Brent felt that this doctor had made an informed decision and shown throughout that he was interested in him personally.

During the night nursing staff had watched over him constantly and the next morning Dr Scott returned to see how Brent’s night had been. A thorough check, a joke, some talk about diving and the future, then Dr Michael Scott was on his way. Check-ups by Dr Scott were regular through to the day Brent was discharged. Thoroughly professional care based on years of specialised interest and work meant Brent left the hospital with a secure and trusting feel toward Dr Scott. In fact he communicated by email with Dr Scott monthly for a short period to report his recovery. This doctor’s professionalism and care had been a shining light in an otherwise alarming incident. (M#3:308)

Brent trusted this practitioner. While his trust did not remove the objective, life-threatening risk, it did alleviate his subjective perceptions of risk and reduce his vulnerability. Thus, in this very positive experience of trust, Brent found that he was

able to cope with a major health care crisis - to the point where he could actually relax and share a joke with the practitioner.

Theme 2: Evidence

In which The Man arrives at the garage and meets the mechanic. The garage is busy, cars up on hydraulic hoists, mechanics moving around them with equipment and tools. In one bay a couple of mechanics talk together, reaching down into the engine of a car - same make as his but a couple of years older. Tools hang on the walls, matched to the black tool shapes painted onto the walls. Other tools lie on oilskins on the floor, close to the mechanics using them. On the workbenches there are more toolboxes, special kits of wrenches and spanners. There are also computers, screens flickering. And half-drunk bottles of Coke. Buxom blondes clad in suede tassels and draped over engines watch down on the workshop. The Man parks his car outside and walks up to the nearest bay. One of the mechanics, an older man, slightly balding, puts down a clipboard on the bench and strides toward him, smiling. From the back pocket of his overalls he pulls out a cloth and wipes his hands. "Hi there – what can we do for you?" he calls out above the noise. He shakes The Man's hand and they move over to the car.

Proof of PHCP Trustworthiness

Throughout both their negative and their positive experiences of trust the men looked for evidence that demonstrated that the PHCP could be trusted, or not. Described also as "cues" (R., M#1:1729), "signals" (Brent, M#5:2557), "symbols" (Brent,

M#1:1741), and “signs” (Dave, M#2:692), this evidence provided the men with extra proof that supported their building – or not - a trusting relationship with the given practitioner. These men gathered this evidence in a variety of ways, from both inside and outside the patient-practitioner relationship. At different times the proof was discerned by the patient in a subtle change in his health condition (Brent, M#1:153), observed on a TV monitor (Dave, M#4:112), experienced tangibly (R., M#3:364), or sighted visually (Jimmy, M#2:491).

Proof of Progress

Proof of progress, or evidence of positive changes in their health as a result of seeking help from a PHCP, was particularly important to these men. They understood improvement in their health variously as evidence of the practitioner's competence, an endorsement of their decision to consult this particular PHCP, and/or a measure of the return on their investment (of money, time, Self). The relationships that these men started with PHCPs were driven by their need for a ‘fix’; thus the over-riding goal of the relationship was to ‘fix’ the health problem, at best to cure it completely, at the least to engineer “an improvement in the situation” (Dave, M#4:2668). If there was no progress toward this goal, the ‘fix’, there was no point in having a relationship: “Brent just said, ‘Blow this. I’m not going back to this [PHCP] because just sitting and listening and doing all the talking with the counselor never seemed to make any progress” (M#4:1930).

Lack of progress toward improved health eroded patient trust, sometimes acting as a trigger in the breakdown of trust, especially in the early stages of a patient-

practitioner relationship. At other times, lack of progress acted to confirm existing doubts about the practitioner. For example, during Dave's mental health episode, the family GP who had earlier lambasted him went on to prescribe medication that exacerbated Dave's condition:

Within two days, Dave's mental state had deteriorated to the point of his needing to be hospitalized for three days. He was taken off the anti-psychotic medication that been prescribed over the phone – based on the GP's conversation with the psychiatrist – and was prescribed an anti-anxiety medication instead (Dave's individual narrative, M#3:198).

Dave lived the rapid decline in his state of health (i.e. negative progress) as further proof that, as he had begun to suspect, this practitioner was not to be trusted.

Proof of Treatment

The collective also discussed their need for evidence that treatment actually had been received from the PHCP. In the next extract, Jimmy situated this type of evidence in relation to trust very clearly, when he called it an "affirmation" of patient trust, in the context of positive trust experiences for these participants. During the following analysis, developed around health care contexts in which Jimmy, Brent, and Dave had watched on a monitor above them as procedures were performed on them, the collective also made clear links between evidence and the credence and experiential properties of health care services (Mitchell, 1994; Mitra, Reiss, & Capella, 1999; see Chapter 2 for discussion of service characteristics) as lived by these participants.

Jimmy: There was an affirmation of trust because you could see...

Brent: 'Have you had the experience?' That's what you have to ask yourself....To be able to sit there and watch it on a little TV monitor was great...I could see what was going on, what they were doing, what they were hunting for, what they'd cut out...

Jimmy: It's a distraction but it's also coming back to what we've said earlier – that it's knowing what the hell is going on (M#4:1653).

R.'s experience of a therapy performed by the faith healer Peter, underscored the need of these men for evidence in health care in general, but particularly in an encounter that belonged, along with counseling and cognitive therapy, to a group of totally intangible health care services. In this group of health care services there is nothing tangible in the treatment – treatment does not necessitate any physical contact by the practitioner, neither does it depend on technology (tangible) or drugs (tangible). The 'treatment' itself took no longer than 15 minutes and R. just lay there while Peter waved his hands just above R's body, using the sort of motion you'd use when cleaning windows. Occasionally, the action would be more exaggerated over certain parts of the body - as if there were a stain on the window and you were rubbing frantically to get rid of that stain – especially around the ears. R. was struggling to understand how this could possibly be doing anything, since there was no physical contact at all, and no sense of anything 'being done' to him at all. Thoughts of the futility of the whole thing began to re-surface, and when the session was finished there was no change whatsoever in the tinnitus. (M#1:713)

Similarly then, in this negative experience of trust, evidence was used by the patient as confirmation. This time however, R. made sense of it as confirmation of his lack of trust, rather than of positive trust as the other three men had in the previous example.

Physical Evidence

Another type of evidence commonly sought by the men was physical evidence, again a concept well developed within services marketing literature (e.g., Bitner, 1992), and conventionally understood to be used by consumers as a surrogate indicator of

service quality. The men's use of physical evidence in this research indicated that they used it also as an indicator of practitioner trustworthiness. This insight raises important questions about the nature of the connection between the phenomenon of trust and construct of service quality. For example, should trust be regarded as a distinctly different construct from service quality, or is there a recursive relationship between the trust and service quality?

Physical evidence used by these men commonly comprised signage, car parking, location and style/state of the building from which the PHCP practised, décor, room layout, certificates on display, opening hours, the dress of the PHCP, and professional fees. Apparently most used in the early stages of a patient-practitioner relationship, physical evidence helped to 'set up' trust before the two had met, and then later, to foster the development of trust:

Jimmy: Until I'd seen the doctor I was the same [as the other three men]. [I had] a very positive feeling about the whole thing...the modern facilities...

R.: Oh yeah. Yeah, total trust – or as near as you can get to total trust – in the fact that you can go to a GP and you can get a result.

Jimmy: So feeling totally happy and trustful right up to that point.

Brent: There's a similarity that I noticed was that there's a comment about 'clean and organised', 'new facilities', 'run-down, worn carpets and faded curtains'. So there was this perception about the person that you were going to see, based initially on...the surroundings...

Jimmy: The environment.

R.: Mmmm. Yeah, physical cues. (M#2:674)

According to the health care needs of the individual, different aspects of the health care experience were interpreted as physical evidence, or these men made different sense of the same physical evidence. For instance, several of the participants needing complicated dental work done lived the spacious, hygienic, high tech type of the clinic surroundings as assurance of the practitioner's technical expertise. In a different situation, the small, relatively messy room (old bookcase and desk, and boxes of books) of Brent's new GP served to reassure Brent. For Brent, needing a GP who would help him with some serious emotional issues, the physical evidence encouraged him to trust in this GP as a man to whom he would be able to relate easily and entrust with his deepest feelings and concerns:

Brent: ...the room ...felt like it wasn't a sterile clinic that you were going to be measured and pummeled and all the rest of it, you know. There was junk lying around, there were things here and things there.

Jimmy: It was a 'blokes' joint!

(Laughter.)

Brent: Yeah. Actually, come to think of it, it was almost like 'a shed down the back'. It wasn't quite, but it almost was – 'a shed down the back, overlooking the river'. (M#2:1445)

In the dental clinic example, the men wanted health care that was more 'cure' than 'care' in nature (see Chapter 3: Concepts and Connections for a discussion of these dimensions of health care, as presented in the services marketing and health care literatures). In contrast, Brent knew he needed more than another round of "routine questions and probes that resulted in the same old responses and conclusions" (M#2:1287). This time Brent's health care needs centred more on 'care' aspects than 'cure'. In both situations, the physical evidence told these men that they were in the right place.

Thus, the men interpreted physical evidence to indicate very personal qualities of the practitioner as a human being, such as benevolence or integrity. In the following example, taken from the group's analysis of their visits to alternative PHCPs, the collective revealed how physical evidence could be used to prove the practitioner's professional legitimacy and credibility, as well as to indicate his empathy and authenticity, which would be important to the relational quality of the patient-practitioner relationship.

Dave: Yeah, you see, I think Dave based his assumption about [the PHCP] Graham's qualifications purely upon all the books that were there.

Brent: Yeah I noticed that.

Dave: He can't remember seeing a certificate on the wall.

Brent: 'A bookcase on the wall is overflowing with books on alternative health care.' [A line from Dave's individual narrative] And Brent had...actually seen a bookcase too, from memory...

R.: Brent had had some cues as to the legitimacy of this practitioner by virtue of the certificates that you'd said were there. . . And there were some cues here [in Dave's individual narrative], no question of that. The books and the bookshelf and the overall sort of environmental setting.

Dave: [Dave] felt that this person was a caring individual, someone that you could relate to.

R.: And the burning of the incense fitted with any preconceived notion he might have had as to what kind of role this person had to play.

Brent: Yes, because as you say, Dave had knowledge of those things. R. was going into something completely different and almost devoid of any symbols that showed that this particular practice was authentic. (M#1:1714)

Money

Money, specifically the fee charged by the practitioner, was used by the men as a powerful indicator of their trust in the PHCP. A high professional fee was evidence of the trustworthiness of the practitioner, as explained in the next extract, in which R. discussed the fee that he would be charged by a cognitive psychologist he was about to consult:

R.:...I also knew it was going to cost me \$250 an hour, and that affected my beliefs about the quality of this person. I thought, 'Right, well at least I'm getting the best person in Hamilton'.

Jimmy: 'They cost so much they must be good'.

R.: Exactly. Yeah. So there were those two things [GP's referral and fee] working at the outset for me to place total trust in this person. (M#4:1823)

Money was not an issue for these participants when they trusted PHCPs, which, in itself, they understood as a verification of their trust in those practitioners. This common-sense was exemplified in Jimmy's explanation of his attitude toward his current dentists and their fees: "They're saying 'We'll monitor [the wisdom tooth] and see how it goes'. And that can be almost like an indicator that says 'Well I trust these guys because they're not out just for my money – they're looking after my best interests'" (M#5:2536).

In their negative experiences of trust these men regularly used the professional fee as a bottom-line measure of the patient-practitioner relationship. They expected to receive value for money in their health care transactions (M#5:1028). So, when they felt that trust levels were in debit, money became the quick, efficient baseline in a

rational value-for-money evaluation of those relationships. For example: “Sometimes I walk out of there 60 bucks down – 40 bucks for the doctor and another 20 bucks for the standard prescription – the value you got for your money just wasn’t there at all” (Jimmy, M#2:1711). Often, as a result of this type of evaluation, money was interpreted as corroboration of ulterior motive in the practitioner, when the patient suspected that the practitioner was out to make a profit from his vulnerability and/or ill-health. Further on in his relationship with the psychologist, when R. had begun to question her treatment, the \$250 fee became more evidence for R. of her untrustworthiness:

He had wanted to get on with learning about the tools of cognitive therapy that he could actually use, but instead he'd been wasting his time discussing goals. 'Had this just been a ploy to rip him off for an extra \$250 a session,' he wondered. Again, far from being inspired to trust in her skills and expertise as a professional psychologist, the second session only made him more skeptical (R.'s individual narrative, M#4:1852).

In my view, she's a quack because she took my money and she didn't do anything for my money. (M#4:2347)

Finally, these participants collected evidence over the course of their relationships, from before they met the practitioner to during each subsequent consultation:

You keep getting things all the time and they might be verbal signals, they might be something that they've done, it might be something that you see around their room, the way you're treated at reception, or something like that and they either increase your trust or subtract from it. (Brent, M#5:2556)

It is important to note also, that on occasion R. and Dave both actively designed tests for practitioners to “prove their worth” (Brent, M#1:546). The practitioners’ responses to these tests constituted critical evidence, which the men then used to adjust their level of trust in the individual PHCP accordingly.

Theme 3: Autonomy

In which The Man tells the mechanic exactly what's been happening with his car – how the car's been driving lately, noises he's noticed, subtle changes in how it's been handling. The Man and the mechanic discuss the likely mechanical problems, The Man letting the mechanic know that he has already checked out thoroughly some of the possible causes himself.

Self Determination

This aspect of the men's trust experiences concerns the men's sense of self-determination within their patient-practitioner relationships. It relates directly to the maintenance of Self integrity, their independence as a separate person within the context of those relationships, and finally, their perceived right as an individual to govern himself according to his own reason. Predominantly cognitive in nature, autonomy as lived by these men involved evaluations both of His own position at any one time, and of the position that the practitioner was taking relative to the patient and his health goals. While there are distinct elements of power and control to this sense of autonomy, this aspect focuses on these elements as they are contained internally within the individual male patient and how they impact his trust in the PHCP.

(‘Autonomy’ constitutes a sub-theme of the theme ‘Agency’, a major theme which underlies the trust experiences of these participants and which will be fully developed in the next chapter.)

The men did not identify 'autonomy' as an issue as such; rather, 'autonomy' was as an assumed base to their health care experiences, an integral taken-for-granted part of their way of being in a health care context. In this form it ran through their work (generally quietly), indicated across their experiences in their self-reliance and the exercise of self-determination within their health care relationships.

Specifically, autonomy was discernible most clearly in the participants' patterns of self-diagnosis, self-education, and self-monitoring; all of these were common aspects to their patient behaviours. Generally, the men had diagnosed the health problem before going to PHCPs:

Brent: We are good at self-diagnosis...

Mary: What do you mean by 'good'?

Brent: I guess good's not the right word but I mean it's probably one of our ...

R: Modus operandi.

Brent: Yeah and the downfalls I guess is our, you know, the fact that we do think we can self-diagnose easily and readily.

R: We like to think we can.

Brent: Yeah.

Mary: So you do it before you think about going to the doctor?

Jimmy: Yeah.

R: Yeah.

Brent: Oh, hell, yeah. There might be a fleeting thought goes through – 'I should go to the doctor' and then no, we'll find a reason for what we've got, you know, so we can assign it to something that we've done recently and that's what it will be from, so ... something that we've eaten...

Jimmy: Well it could be a more serious thing or ... my heart's going crazy about my food poisoning, man ... shouldn't have

eaten that chicken or whatever ... it's like ... hidden ... I just think that oh...

Brent: 'I need to drink a bit of water and sleep that off'...(M#1:1714)

As Brent intimated in that last line, once diagnosed, the men tend then to conduct an information search (using internal and/or external sources of information), decide on some appropriate course of self-treatment or way of managing the health problem, and then wait for the body to heal itself. If, given time, their bodies did not heal themselves (“...he left it for a further week until it was clear that the discomfort wasn't going to go away of its own accord”, Dave, M#5,1152), then the men sought outside help for fixing the problem. Often, they presented with the diagnosis and firm ideas on what was required to effect a cure.

Knowledge and Voice

‘Knowledge’ and ‘voice’, two of the vital stand-alone facets of the women's trust experiences, also played important roles in the men's trust experiences. However, for these participants, ‘knowledge’ and ‘voice’ were lived as constituent aspects of their autonomy, rather than as significant themes in their own right. The men expected to be given knowledge relevant to their health care situation by their PHCPs in order “to be able to know and understand and make an informed decision” (Brent, M#5:2450). Types of knowledge named by these men included information about practitioner and patient roles - especially in unknown health care environments like alternative therapy clinics (e.g., Brent, M#1:31, 821), treatment details (e.g., Dave, M#1: 1577, 1687), knowledge about health care delivery processes (e.g., R., M#1:706), health

philosophy (e.g., Dave, M#4:2716), as well as specific details about the patient's condition (e.g., Jimmy, M#2: 2511).

Knowledge thus provided by the PHCP facilitated the patient's decision-making and hence supported his autonomy. Conversely, when the participants perceived that PHCPs had with-held knowledge, they regarded this as an indication that their autonomy was under threat, which in turn impacted negatively on their trust. Similarly, when these men volunteered personal inside information to PHCPs, they expected it to be acknowledged and "explored" (Brent, M#4:2210) so that the practitioner could make informed decisions also. Lack of attention to personal knowledge volunteered by the patient, or inadequate (unfocussed and/or non-productive) questioning by the PHCP to elicit such knowledge was a major cause of frustration for these men:

Jimmy: It's hard to know what [information] you have to give...What do I tell the doctor apart from 'I've got this problem. It's supposed to be their expertise to say 'OK, right.' Ask these questions and look in here...(M#4:2216).

Brent: It's like, 'You ask me the initial question and I'll give you some information' and then the thing is 'Well, what do you need to know next to help you with your diagnosis?' Not 'I'll just keep rambling on and telling you about all sorts of things that may be irrelevant.'

R.: That's right. And which will effectively be wasting our time together – not just mine but yours too. And you know, 'Let's be efficient – time efficient – about this'.

Jimmy: And coming back to the car thing. You know, the mechanic always asks 'What's wrong? Have you done this? Does it do this when you do that...?' They always ask questions straight away. (M#4:2262)

When the participants voiced concerns, or individual wants and needs – all of these can be understood as articulations or declarations of autonomy – these men expected

the PHCP to listen actively, as did the female participants. PHCP deafness or dismissal of the patient's knowledge and concerns immediately "diluted" his bucket of trust (R., M#4:2247).

Evaluation by Patient

Throughout the relationship with the chosen PHCP, these men ran random checks on various aspects of the interaction. Brent double-checked with his mother the diagnosis of the alternative PHCP (M#1:167); R. monitored closely the efficacy of various treatments for improvement in his tinnitus (M#1:682, M#4:1871); Brent analysed the consultation process itself (M#1:621); Dave regularly checked practitioners' behaviour for signs of inconsistency (M#1:1334) and tested the professional integrity of the dentist who was about to replace his amalgam fillings for him (M#4:134); Jimmy assessed the commitment of the GP toward achieving his health goals (M#4:2802).

'Self' Control

The participants trusted those PHCPs who respected their 'expert' knowledge about themselves, and allowed them the room in the relationship that preserved or reinforced their sense of autonomous Self. In contrast, the men interpreted relational situations in which they felt their personal power and control were compromised as threats to that sense of autonomy or as a disregard of their assumed right to agency. Such experiences commonly resulted in the breakdown of trust (Dave, M#895), although sometimes the men attempted to actively re-structure such relationships in

order to achieve their health goal, usually when their treatment/practitioner options were limited, e.g., R., M#5:132). It was also common for these men to tacitly terminate the relationship entirely (e.g., R., M#2:436; Brent, M#2:1341). In their role as patients, then, this sense of self-contained autonomous Self was very important. The men's experiences indicated that trust was best able to develop in those patient-practitioner relationships in which their autonomy was acknowledged, respected, and remained intact in the interaction.

Of course there were situations in which the men did not expect or want to exercise Self-control. In these situations patient agency was perceived to be inappropriate and unproductive. In accident and emergency encounters, for instance, when the patient had suffered serious injury, then participants expected a PHCP to take control, to take responsibility for making the immediate diagnostic and treatment decisions, and to concentrate primarily on getting the metaphorical car back on the road. Certainly, the men appreciated sensitivity, empathy, and respect at these times, but they constructed their trust largely on the professionalism and technical competence of the practitioner. R., reflecting on his treatment following the motorbike accident, made this comment:

There wasn't really much of a great deal of feeling going on. There wasn't really a sort of an emotional response at all for me. It was matter of fact. And the fact that I was looking for cues to be part of a system which seemed to be very professional and seemed to work very efficiently, and seemed to have the latest equipment and so on, that was really all that mattered because of the nature of the injury, I think. (M#3:2193)

Later in the same collective de-construction of trust, triggered by the topic "An urgent encounter with a PHCP", the men referred again to relinquishing their autonomy:

...it's not like you can stitch yourself up or clean your own wound. And in [Brent's] case there's embolisms and

punctured lungs – you know, you can't do that. In [Dave's] case, it's like none of us would know anything how to treat any sort of mental state if we had to...

Dave: In an emergency, you must be more out of control of your own welfare than any other time, aren't you?

Brent: Yeah, you are.

Dave: You've got to hand over that ...

R.: Accept somebody else's expertise over and above...and judgement over and above your own. Yeah. They have a specialist knowledge and skill and experience to bring to bear...(M#3:734)

Patient's Best Interests

The most trusted PHCPs in these health care situations were those who demonstrated professionalism and technical expertise, and at the same time engendered a sense in the patient that the patient's best interests were paramount. The men regarded these PHCPs as allies and advocates, who would "stand alongside him" (Dave, M#3:169), act as their agents, and make decisions based on what was best for the patient. It was interesting to note the references that these men made to feeling relaxed with such trusted practitioners (e.g., Brent, M#3:334; Jimmy, M#3:242; M#3:1701). Taken together, these references suggested that in certain circumstances these men welcomed the abdicating of self-reliance and responsibility, and experienced the letting-go of their autonomy as a relief.

A fascinating insight to the dynamics around autonomy for these men was afforded by their work on an experience of Brent's, in which he felt as though he was compelled, unreasonably, to exercise his autonomy. Brent felt that he was having to self-guard his best interests himself, at a time when he was not in a fit state to do so. He understood

that this had come about due to professional incompetence, when key emergency staff had not taken full responsibility for him when they should have. Their 'un-professional' demands on his autonomy sparked indignation in Brent and contributed to his negative trust experiences with them. Brent and R. began to develop the collective understanding thus:

R: That sense of frustration came through the narrative at all sorts of levels, but it seemed to me there were two...fundamental responses coming through from Brent. One was the sort of feeling that he was having to take, almost in annoyance - an acceptance as well - that he was having to take quite a lot of responsibility for informing the doctors for them to make a decision about what was wrong with him...

Brent: Yeah.

R: ... and he had to maintain this sense of perspective and objectivity somehow, under these extreme circumstances. And almost separate off himself from himself.

Brent: To be able always to retell the same damn story, over and over again.

R: Yeah. Yeah. And that frustration and annoyance came through and that was sort of mediated through his perceptions of the various healthcare practitioners during the day. Some of them were more adept at getting that story out of him, making him feel comfortable with the fact that he had to take that responsibility, whereas others weren't - would that be fair?

Brent: Yeah, that would be a very fair insight into it.

R: And then, of course, there was the emotional response that was coming out from Brent which was the feeling that you know all, he didn't want to take that responsibility, he wanted other people to take responsibility, he wanted people to comfort him, to look after him ...

Brent: Being the consummate professional that Scott was, in the end he did take responsibility for those things - by observing me over a long period of time rather than just sort of dealing with me momentarily and then putting me aside, or dealing with me and then passing me on for somebody else, and then me having to retell the story to the next person that I got to. And the next person. And the next person.

R: Yeah, it was almost like finally there was somebody that was doing the job and without you having to do it for them, in that kind of sense.

Brent: Yeah. (M#3:1560)

Two other autonomy issues discussed by the group also had serious negative consequences for individual patient trust. First, when a PHCP wrested control from the patient (e.g., Dave, M#3:176; Jimmy, M#4,2802, 2813; R., M#4:1986). Second, in a more insidious manner, when the patient perceived he had 'lost' his control to the practitioner (e.g., Dave, M#3:712). When these men decided to defend their autonomy, any of the situations in which these men felt that their autonomy had been compromised or threatened could lead to power-and-control type struggles between the patient and practitioner. These will be discussed as a relational pattern in Theme 12: Trust as Alliance, and expanded in the next chapter.

Theme 4: Personal Connection

In which The Man and the mechanic stand together talking. They stand beside each other, arms folded against their chests, legs astride, sometimes one rocks slightly from heel to toe. They talk about Saturday night's game to begin with, then both move toward the car. The Man puts his hand on the roof and leans in towards the mechanic who is now in under the bonnet bent over the engine, hands moving over things, checking, as they talk. The mechanic is listening to The Man tell him about his car – how its been driving lately, noises he's noticed, fuel consumption, how and where he drives it, idiosyncrasies it's had from Day 1. The mechanic nods, asks a question every now and then, looks up to speak to The Man occasionally, then straightens up when The Man seems to have finished, wipes his hands and moves

back to The Man to stand beside the car. Again they talk together, now about the car. As they talk, they alternately face the car then turn to face each other. The mechanic tells The Man what he's found in his mechanical checks, what the repair options are. The Man talks about what his plans are for the next few weeks, when he needs the car, financial considerations. After a few minutes they have decided on the best option. The mechanic pats the car on the roof, then cuffs The Man on the shoulder, and they move off.

This phrase, 'personal connection', is a merger of two strands that underpinned the trust knowledge of these men. This section, accordingly, pivots on the importance they give to

1. being known by the PHCP as a person in his own right, an individual, who is distinctive from all of the practitioner's other patients, and
2. forging a particular type of bond between him and the practitioner, best described as a connection.

Patient as Person

Over the research the participants constructed a composite picture of this facet to their trust. It centred on an awareness that the patient was being related to by the PHCP in a "very personal kind of way which was individual for him" (Brent, M#3:1996); or, as Jimmy described it, the awareness that the PHCP actually cared for the male patient "as a person – not just as another leg coming through" (M#3:2357). The male patient existed in the relationship as an independent human being, with a personality and place in the world that marked him as an individual. In the absence of a personal

connection between them and their PHCPs, the participants commonly reported feeling like they were on a production line (e.g., R., M#4:2476), merely a number on the day's patient schedule (e.g., Jimmy, M#2:1737), a 'meal-ticket' for the practitioner (e.g., Brent, M#4:2145; R., M#2:1689), or a particular body part or condition (e.g., Jimmy, M#1:2854). Dave also experienced being treated as a position in the family, related to by the family GP as a son rather than as an independent person in his own right (M#3:559).

The participants frequently used the language of machines to describe experiences in which they perceived that the practitioner did not care about them as people: they talked about 'conveyor-belt' health care (Jimmy, M#2: 1408; R., M#1:860), being on the practitioner's 'production line' (R., M#4:1971; 2477; Brent, M#2:1976), and PHCPs who were robotic in their relational responses to the patient (Brent, M#4:1137; R., M#4:2066). In these negative experiences, the men had been de-humanised. In their experiences of personal connection, their humanity was assured.

Life Context

The group noted that "these characters", the men of their individual narratives, wanted the PHCP "to know about them totally" (M#2:755; 1009), not just the symptoms they were presenting with. This total knowledge embraced such aspects as the immediate dimensions of the patient's illness experience (e.g., R., M#4:2024), his personality (R., M#5:147), family circumstances (e.g., Dave, M#3:559), employment situation (e.g., Jimmy, M#4:2846), lifestyle (e.g., Dave, M#1:1387), the social implications of

illness for this individual (e.g., R., M#4:2474), and the important events marking the patient's stage-of-life (e.g., Jimmy, M#5:790). Jimmy described this facet of his trust:

He [the GP] would discuss things like rugby and he had a good old laugh because I wasn't into rugby...he actually found out what made me tick, what I liked, what I was doing, where I was at. You know, 'What's your wife up to? Where does she work?' kind of thing. (M#2:2648)

This 'total person' approach ensured that The Man was both understood and treated in relation to the "real things that were happening in his life" (Brent, M#2:1300). Thus, a Personal Connection respected him as a separate, unique, self-determining person, and honoured his self-identity and perceived position in the world: "You want to be in a situation where you can be respected" (Dave, M#2:1928).

Professional Intimacy

A Personal Connection was characterised by a specific intimacy, which the participants explored firstly, by reference to that experienced in close friendships. Later, they refined their construction of it into the notion of professional intimacy, which encompassed the safety, honesty, and depth of sharing that was possible for the male patient in the relationship - but stopped short of having a beer with the PHCP (see M#2:1300; M#5:1776). R. expressed this sense of intimacy, as well as what it meant for him as a patient, in this insight:

I've just realised that what I would really like is if somebody said to me "Here's a magic wand and you can have any sort of a GP that you like.' I'd like to go and talk to a GP as a mate. As a pal - an actual pal. And be able to really discuss it [tinnitus]. Because that's the problem that I've got - I feel as if I can't discuss what's really going on. And it's a frustrating feeling. I can't discuss it to give it its due-ness. In its full entirety. (M#2:1741)

The participants lived this professional intimacy as a confidence that their PHCPs were relating to them at that moment in time, that the practitioner was totally focussed on the individual and paying full attention to him, and that practitioners had a “fix” (R., M#4:2472), or a deep understanding of the effect of illness in the context of his life because of their knowledge of the patient's personal circumstances. These men understood that professional intimacy provided the base required for the practitioner to intuit and then meet the patient's individual needs at all levels involved – emotional (e.g., Brent, M#2:1366), cognitive (e.g., Brent, M#2:1287) social (e.g., Collective, M#2:2130), psychological (e.g., R., M#5:148), spiritual (e.g., Collective, M#2:1861), as well as “the old-fashioned physical stuff” (R., M#2:2132). Conversely, certain occasions on which individuals had had to repeat their health story to PHCPs (e.g., Jimmy, M#2: 771), or to spell out their own needs for the practitioner (e.g., R., M#5:148) were interpreted as evidence that the particular PHCP was not relating at an intimate level with the individual as a person.

Rapport

Rapport was critical to developing and sustaining a personal connection between these patients and their practitioners. In the early stages of a relationship, rapport set up the relational space in which the patient felt relaxed and secure enough to begin to entrust the practitioner with his intimate, personal details. Later, in established relationships, rapport provided the space for re-connecting at a more superficial level before relating at a deeper person-to-person level, a chance in this encounter for both the patient and the practitioner to remind each other that they knew the other as a human being, and that together they could connect at this very personal level. There was a distinctive

'blokey' flavour across the participants' descriptions and interpretations of this rapport:

The GP that I've learned to trust at the moment...we actually spend probably the first five minutes talking beers, we talk crap for five minutes, and then...the funny thing is, you know, he's able to diagnose and fix whatever the problem is very shortly...he's got a good manner where you learn to trust and you find out a bit about him too, what he does, what his hobbies are...and even though you rarely go in there he still actually knows...you now, 'How's the house coming on?' or whatever. (Jimmy, M#5:782)

And, from the group's analysis of Brent's individual narrative of his first visit to a new GP:

Brent: He [the GP, Wayne] talked about things a lot; and talked about lots of things. Brent can still remember that first visit and the joke, you know, and I mean it wasn't a clean joke that Wayne shared with Brent – it was a good bloke's joke and that was probably, I mean the language that he used, he obviously was a perceptive person and had discovered in the first five or ten minutes where he stood with Brent and so was able to talk in that manner and knew that he would get away with it, and Brent doesn't mean get away with it in that he was transgressing any patient-doctor boundaries or anything, but...

Jimmy: He just read the person well.

Brent: Mmm. And knew that 'To be able to relate to that person I need to be doing this to get there'. (M#2:1667)

In these rapport experiences, then, the men revealed their interpersonal connections had a certain gendered character. While the men definitely enjoyed building up in their collective analysis a 'male-thing' sub-theme (M#2:1780), which included the 'male' jokes and humour (in particular), work and sport talk, their work also offered a much more serious insight to the place of gendered exchanges in these relationships. The gendered connections detailed by these men apparently served to reinforce for the male patient that it was safe for him to be relating to this PHCP; that, in effect, his

gender identity was being acknowledged and would be respected within the relationship.

This can be understood as what is commonly referred to (and often trivialised in the process) as 'male bonding', seen here at work in various health care contexts: "He was a man before he was your doctor" (Jimmy, M#2:2647). While, at times throughout the research, the men themselves also seemed to trivialise their examples of male bonding, the detail in their narratives and collective analysis underscored the importance of these gendered connections in their trust experiences.

Individualised Care

Integral also to the experience of personal connection was the men's sense of individualisation of their health care, which they regarded as both a natural consequence and the practical manifestation of professional intimacy within the patient-practitioner relationship. When there was a personal connection between PHCP and male patient, the participants felt that their health care was tailored to fit them as individuals. These men experienced health care as individualised when it matched the individual's "requirements" (R., M#5:561); when it was designed, by taking into account relevant information about his personality and lifestyle, to be the 'best' health care treatment option for him in the wider context of his life. Thus, "first of all, the PHCP would be interested in you as a person, and then the [health] problem, and then 'These are some of the solutions I can offer'." (Dave, M#1:1337).

Implicit then in the men's development of the Personal Connection facet to their positive trust experiences, was the expectation that they would be treated by PHCPs as a total person, with mental, psychological, spiritual, emotional, social, and/or bio-physical needs, depending on their immediate health care circumstances (see collective analysis, M#2:1968). PHCPs with whom these men felt they had a personal connection were able to consider and relate to these men individually, sensitively, and appropriately, in response to the patient's particular needs at the time (e.g., Brent, M#5:2346). These needs varied in nature and salience, for each individual, over time, and across health circumstances:

We're wanting them [PHCPs] to be all things to all people, and specific to that particular moment in terms of our problems at that moment and how we feel. On the one hand I want somebody – you know, on the previous occasion – to have reached out to me and to have been understanding in showing a great deal of empathy, and yet today I've been wanting exactly the opposite. I've been wanting a job to be done as quickly as possible. (R., M#3:2586)

The ideal PHCP for these men, then, whom the collective constructed from their most positive experiences, adapted to the individual's changing needs as a patient, adjusting relational responses and elements of the treatment to meet his needs (see collective analysis, M#4:2479, 2844). Participants reported that, in their experience, such adaptable PHCPs were perceptive in assessing the patient's needs, and integrating the overall health care treatment with the other important aspects of his life, regularly checking the 'fit', and discussing any possible changes in treatment with the patient.

The men realised that these personal connections involved "bridge-building" skills (R., M#4:2470) of the patient as well as the practitioner. The patient and the practitioner were joint engineers. The connections between these men and their

PHCPs were co-created; thus, their own behaviour could have a major mutual and reciprocal influence on setting up a relational environment in which their distinctive individuality was preserved, and their personal power respected. So, although they indicated that they preferred the practitioner to manage the relationship (see M#4:2181), at those times when these participants perceived that the personal connection that they wanted was not happening, they made deliberate efforts themselves to correct the patient-practitioner dynamics.

For instance, in an incident cited earlier in this chapter, before going into the consultation with a PHCP, R. devised a strategy for deepening the bond between them, and better customising his health care treatment. This strategy included disclosing important personal details about himself that the practitioner apparently had not discerned in their relationship up to that point; itemising the psychological, emotional, and social effects his health problem was having on his quality of life; and making a clear declaration of his needs as the patient (M#5:144). Brent and Jimmy, too, described occasions when each actively elicited personal information from the practitioner in order to encourage a more intimate professional connection between them (Brent, M#5:2292; Jimmy, M#5:788).

These men spoke about a gut feeling that they experienced with regard to the quality of the personal connection between them and the PHCP, and the personal character of the practitioner: "Just whether or not you feel as though you get on with them as a person, and whether or not you think they're a decent guy or not" (R., M#5:1714). Participants indicated that they respected this "profound" (R., M#5:1729) inner sense, or knowing; they trusted themselves and their intuitive awareness of the state of the

relationship. An awareness that there was no personal connection happening between him and the PHCP, or that their relational connection was breaking down, seriously undermined the patient's trust in the practitioner (e.g., R. M#4:1845). Indeed, at times, such a gut feeling could be instrumental in the patient deciding to discontinue the patient-practitioner relationship (e.g., M#4:2569).

Finally, this sub-section finishes with an extract from the collective's reflections on an interesting paradox that the men recognised in their desire for a deep personal connection with their PHCPs. They noted the difficulties in developing such a personal connection that would both respect their autonomy and reinforce their sense of male self, and enable the practitioners to discern and meet their needs efficiently, given the culturally prescribed once-every-seven-years norm for their visits:

Brent:...We're talking about trying to get to know a GP [PHCP] and a GP [PHCP] that might know us on a personal basis , and yet one of the things that we are constantly saying as guys is 'We don't go to our GP [PHCP] unless there is something really, really wrong with us. We need more than a scratch.' Are we asking for GPs [PHCPs] to be something more than we can expect them to be? Like... we go once every seven years and we want them to know us personally when we get there...

R.: Yeah. But then the other way of looking at it would be: Are we putting the cart before the horse, or the horse before the cart? Because if we did know them, then we would feel much more free and able to go and talk to them...Maybe we would expand our perceptions as to what that doctor [PHCP] will do for us. (M#2:1784)

To summarise this section, which constitutes the 'He' domain of the relational heuristic framing the analysis overall, the male participants of this research developed their descriptions and perceptions of trust as they related to the individual man,

around the four themes of risk, evidence, autonomy, and personal connection. Those aspects of the men's trust experiences that they made sense of by relating most to the PHCP, or the Other domain of the heuristic, are represented in the next section.

7.4 The Primary Health Care Practitioner as 'Other'

Applying the relational heuristic, 'Primary Health Care Practitioner as 'Other'' refers to the domain of the practitioner, to those responses, behaviours, and relational dynamics that the men perceived were located in the practitioner, as opposed to those that were centred on them. As the women participants also did, these men constructed a comprehensive range of attitudes, beliefs, emotions, and behaviours that they attributed to the PHCPs, and perceived as characteristic of their experiences of patient trust (positive and negative). This range of PHCP-centred responses easily constituted the largest of the three analysis sections in the men's data. The data entries in this section reflected a thoroughly deconstructed, finely differentiated range of expectations, experiences, and understandings these men had of their PHCPs, which actually had to be re-assembled into more general categories for presentation in this chapter.

The men's practitioner-centred responses and behaviours are presented using the same format adopted for the women's data; in two sub-sets, comprising those PHCP responses that relate mainly to the 'cure' or scientific-technical facet of the practitioner's delivery of health care service, and those responses that relate predominantly to the 'care' or psychosocial elements of the service provided by the PHCP. This format follows a distinction that the men made clearly and quickly themselves during the collective analysis and theorising of their individual

experiences, and is supported by seminal theoretical work within the field of services marketing (Gronroos, 1984), and health care marketing in particular (e.g., Gabbott & Hogg, 1995). Using the same format for the men's and the women's data at this stage also allows us to identify and appreciate finer nuances in the similarities and differences between the genders as they occur within this domain of the patient trust experience.

Before examining the participants' work in detail it is important that the differentiation of the PHCPs' relational responses into the cure or care facets be contextualised according to how the men lived these two facets within their patient-practitioner relationships. Given the deliberately open mandate to research their 'trust experiences (positive and negative) with PHCPs', these men focussed on encounters or relationships with both cure and care facets to them. This focus, which was spontaneous (without discussion and formal consensus) and tacitly determined by each individual and by the collective as a whole, indicates that patient trust as it was lived and understood by these men, involved cure components and care components. As it was for the women participants, the optimal balance between these two facets was personal for the individual man. It depended on his needs and health circumstances at the time, and could change over the course of a single encounter, a relationship, and/or his lifetime (see collective analysis, M#2:1961).

However, the bottom line drawn by these men concerned results, health care outcomes. These men generally went to the PHCP for "a fix" (M#1:501); in other words, for a solution to a particular health care problem that they could not fix themselves, and which was compromising the quality of their lives. In terms of health

care service delivery models (e.g., Carmel & Glick, 1996; Gabbott & Hogg, 1995; Turner & Pol, 1995), and according to these men, a fix was the result largely of the PHCP's scientific-technical responses, the 'cure' capabilities of the practitioner.

Certainly, while the men revealed that the interpersonal 'care' abilities of the PHCP were central to their constructions of deep relational trust, these same care abilities were not essential to every trust experience. These patients indicated that there were times when care was inappropriate and/or unnecessary because the health care problem was a straightforward mechanical job. However, participants revealed that even in more complex health care situations they were prepared to continue a customer-provider relationship in which they perceived the practitioner did not care for them, but they were confident that the same PHCP could deliver the cure they were seeking. In these circumstances when the men were willing to forgo 'care' for the cure, they lived a trust based on their belief in the competence of the PHCP.

The participants also made it very clear that while they were willing to accept a certain amount of trial and error in the cure process, they were not willing to continue a customer-provider relationship when they perceived the practitioner did not possess the requisite cure competencies, even if they trusted that PHCP as a caring person. They were not willing to sacrifice cure for care.

In their preferred trust experiences, actual and ideal, these men put a high value on a combination of cure and care in their PHCPs' responses to them as patients. In fact, the participants assumed that the PHCPs they trusted would relate to them using both technical-scientific skills and relational skills together; or in the men's own words:

Brent: I think that we're probably expecting that of our doctors and health care people as well, that they...

Jimmy: And why shouldn't we?

Brent: That they don't just have the knowledge and the expertise, that they actually have the personal, the interpersonal skills that go with it as well.

R.: Yeah. Yeah. That's certainly a common denominator across all scenarios so far. (M#3:2626)

The following sections detail the men's perceptions and understanding of the cure and care responses of PHCPs and their significance to patient trust. The 'cure' set of responses, as perceived by the men of this research, relates to the scientific-technical expertise and skills of the practitioner, and the PHCP's proficiency in applying these to the health care of individual patients. The 'care' responses relate to the personal relational qualities of the PHCPs, and the subjective dimension of their relationship with patients.

'Cure' or Scientific-Technical PHCP Responses

In which the mechanic puts the car through a battery of tests. The Man has left the workshop to return to work. The mechanic works alone at this stage, confident, methodical, thorough. He uses a range of standardised equipment, but also hooks up the car to a couple of more specialised, hi-tech pieces of equipment, to give him more detailed info about the car. He also pauses occasionally, to rub his fingers over a particular join in the pipes, or to get in close and listen intently to that noise. He remembers cars like this that he has worked on in the past – actually, come to think of it, that one owned by the accountant from Huntington had exactly the same problem. The mechanic jots down some notes, then pulls up Mike Sheppard's file:

'Ah yes. Just as I thought! Okay. Let's double-check this!' He leaves the file open while he moves over to Bay 3 for the diagnostic equipment he needs. Again, there is a routine to this specific test that the mechanic follows – thoughtfully, with assurance and care. 'Yep, sure enough. That's it – exactly the same problem! Okay. Now, for the options. First up though, the manufacturer sent through an update on that just last week. Let's see where they're up to with it these days.' The mechanic makes some final notes in The Man's file, before getting onto the manufacturer's website. Later in the day he rings The Man on his cellphone. The Man arranges to call into the workshop the following morning on his way to work.

Theme 5: PHCP's Clinical Skills

This set of PHCP responses, as perceived by the male participants, was very similar to that constructed by the women in this research. Both the men and the women considered that getting a solution for their health problem (the primary reason driving the encounter) was top priority in the patient-practitioner relationship (Collective, M#2:2583). Like the women, these men developed direct links between being 'fixed' by the PHCP and placing trust in that practitioner.

Accuracy

Also, the men stressed the importance of accuracy in the practitioners' diagnosis and treatment. The salience of accuracy for the men was reflected in the word 'fix', the predominant term they used for the health care solution they were after. 'Fix' resonates with accuracy. From a Latin word meaning "to fasten, drive in" (Webster's,

1964), 'fix' is defined as to fasten immovably, to arrange definitely, to make permanent, to set firmly, to make rigid, etc. (p. 694). There is no doubt or indecision in this word, no inaccuracy. Accuracy was implied in the men's discussion of a 'good', trustworthy PHCP as "one who would be able to quickly diagnose the problem and recommend a course of treatment that would do the trick" (R., M#2:408), and a "person that not only knew about [the patient] but was able to put the finger straight on what the issue was" (Brent, M#2:925).

Thoroughness

The thoroughness of the PHCP also figured prominently for the men in their experiences of patient trust, as it did for the women in this research. But whereas it constituted a separate sub-section in the women's framework, PHCP thoroughness was subsumed by the men into their construction of accuracy; they regarded thoroughness, frequently lived as methodical, orderly, and unhurried routine, more as a prerequisite step toward the PHCP getting the "result" these male patients were looking for (Jimmy, M#2:2025).

Thoroughness promoted feelings of reassurance (Collective, M#2:941), security (R., M#2:416), and relaxation (Brent, M#3:334), and inspired patient confidence in these participants' positive trust narratives. It also was significant in their negative experiences (as it was for the women). Then these men lived thoroughness as irrelevant (Brent, M#2:1290) and a waste of time (R., M#4:2267), or interpreted it as evidence that the health care they were receiving was limited (Jimmy, M#2:511) or superficial (Collective, M#2:182).

Other Clinical Skills

Also critical to effecting the health care 'fix' and thence to engendering patient trust, were what the participants understood as:

- the perceived basic technical capability, or skillfulness, of the PHCP to do the job (Brent, M#2:924; Jimmy, M#2:862; Dave, M#3:2390);
- the "total competence" (Jimmy, M#2:911) of the PHCP insofar as "he can (a) remove the mole himself, or (b) is able to decide if it has to go to a specialist, if it's beyond Jimmy's doctor's own ability, or (c) if Jimmy's doctor has the confidence to say 'No, that mole's fine. It's not a problem, it's not going to be cancerous'" (M#2:912),
- the PHCP's expertise, described by Brent as relating to more than the patients' immediate physical symptoms; rather to "being able to look at everything and make a judgement about everything that's going on and advise them [patients]" (M#2:1401), and later defined by Dave as the PHCP's "ability to deal with the situation" (M#3:2390), and
- the experience of the PHCP, which enabled the practitioner to identify the problem accurately, "to know where there could be several different reasons for the same symptoms" (Dave, M#2:989), "to pick up on the subtle nuances...and interpret the condition without it just being a mechanical process" (R., M#2:957, 994).

The participants acknowledged that these diagnostic and treatment skills were what made the PHCP the expert in the health care context:

Jimmy: You're not the expert and that's the thing. You're going to this person obviously to get their advice etcetera...

R.: You still want to defer to that when it comes to the stuff that you don't know about – the expertise and the experience, and the stuff that you haven't got. You want to be able to defer to them. (M#5:2465)

The connection between these critical diagnostic and treatment skills and patient trust was conveyed clearly in one of Brent's individual narratives: "Thoroughly professional care based on years of specialised interest and work meant Brent left the hospital with a secure and trusting feeling toward Dr Scott" (M#3:341).

Theme 6: Professionalism

Professionalism, as constructed by these men, was concerned with their expectations of the individual PHCP's practice of health care specifically. The construct thus comprised the generic 'personal' characteristics, or practice skills, that they expected of each practitioner as a professional, as opposed to the more 'mechanical' scientific skills involved in diagnosis and treatment. Coupled with those technical capabilities, the provider's professional practice skills completed the participants' understanding and expectations of the overall role of the practitioner as the provider of their health care. This clear delineation of the patients' expectations of the practitioner's distinct behaviours and responses effectively made it easier for these men to relate to the practitioner as the Other. In this way, the men perceived the practitioner and patient as separate and distinct entities within the context of their relationship, a relationship centred on delivering a health care solution for the male in his role of patient: "You [the patient] feel as though you've got your boundary line, but you also expect them [PHCPs] to have theirs" (R., M#1514).

Participants used the construct of PHCP professionalism across the range of health care experiences they detailed. It was another construct that was implicitly understood and communicated without negotiation or clarification by the men as a group, and its high salience was likewise tacitly implied by the collective in their individual experiences:

“To me, a good GP was...experienced and professional, a highly trained professional...” (Dave, M#2:997).

“R. marveled at the professionalism and speed with which he had been looked after...” (M#3:382).

“I chose this person so I actually trust that this person is going to respect me for having chosen them at the end of the day – because I’ve seen them as a professional in what they’re doing in terms of my health care...” (Brent, M#4:1500).

Professional ‘Personal’ Characteristics

Professionalism, as constructed by these men, involved various characteristics that they expected the practitioner to have. The following two ‘personal’ characteristics were particularly important attributes in the practitioner as a professional:

- Confidence. Specifically, the PHCP’s confidence in “their own professional technique and skill” (Brent, M#5:2789). Evident as a particular ‘authority’ these men experienced in their trusted PHCPs, and experienced by Jimmy in his dental practitioner: “I trust this person so wholly that if they say I need \$20 worth of cleaning then I need 20 bucks worth of cleaning. If I need 900 bucks worth of bridges and holes and extracted teeth or whatever, then that’s OK. That’s what I need...It doesn’t matter what this person says its going to cost me, I trust them enough to know I need it...I trust them in what they’re doing.” (M#5:2504).

- Independence. The men understood 'independence' as being non-judgmental, objective, unbiased: "You can always trust...the doctor...he's not going to rat on you. [He's] not in any way in cahoots with the other important people in the scenario, like the father, the police..." (R., M#3:537; 2454).

Practice Skills

In addition to the preceding professional personal characteristics, the men identified the following practice skills in their construction of 'professionalism':

- Confidentiality. For example: The Man goes into a patient-practitioner relationship with "a belief system that that trust factor is absolutely sacrosanct. *Dave: "Yep. And having that rapport and not being judgmental about the situation." R.: "Yeah, total confidentiality of the encounter" (M#3:675).*
- Credibility. For example: "*I...judge them by whether they [PHCPs] appear to be speaking from some sort of knowledge base consistently...Dave went to a faith healer once and...he lay down on a table and there were other people there praying, and the only mention that was made afterwards was that Dave needed to look after his liver. I thought, 'How could they have focussed on one aspect after just having done this movement over the body?'...unless they could use x-ray vision or sense some sort of energy block. It was just too way out for me to accept...*" (Dave, M#1:1334).

- Knowledge-ability. This concerned the PHCPs' ability to deal with knowledge, to manage it for themselves, and for their patients. Thus, it included *"the ability to go and look at other sources, to go and pick a book up off the shelf while he's talking to you and open it and read it and talk to you about what it is that he's reading...Brent actually sees that as being very professional in that he's not totally...trying to rely on keeping all that information in his head.*

R.: It's not necessarily having all the answers but knowing where to go for the answers and having that information at hand" (M#2:1523).

Knowledge comprised the intellectual 'book' knowledge referred to in the extract above, the PHCPs' experiential knowledge both about human beings and about human health, and the practitioners' relational knowledge about their individual patients. Particularly important to the participants were the ways in which the PHCPs handled their expert or specialised knowledge. When practitioners shared their knowledge with patients in order that they could make a better, more informed decision these men experienced an increase in their trust – *"there's a trust factor...the more a [PHCP] can use that knowledge to make you feel confident, that's done it for you"* (R., M#2:2639).

Similarly, it was critical to these men that PHCPs informed them about what was going to happen to them as patients, particularly when they were undergoing an unfamiliar or complicated procedure, when such information reduced the patient's fear considerably. This 'process information' was crucial to young Jimmy and his trust in the emergency doctor who fixed him up after he had fallen out of a pine tree:

The wound was about 2cm deep and the GP trimmed along the edges in a V shape, narrating as he went, before stitching half way up the wound with dissolving stitches. Then he stitched the outer wound with heavy gauge stitches, stating this was important as the wound was right in a moving joint and needed stronger stitching. All through the procedure Jimmy felt at ease with the confidence Dr Blaise portrayed and by the way he described what he was doing, which left no surprises. (M#3:258)

When the participants perceived the PHCP lacked knowledge (e.g., M#2:421), or, more commonly, did not share knowledge or inform the patient (e.g., M#4:1724), then their trust dropped immediately. These trust patterns constructed around knowledge are very similar to those experienced by the women, although on a smaller scale; the men did not give the 'knowledge' construct as much prominence as the women did.

- **Response-ability.** Participants trusted practitioners who had the ability to respond professionally to both the cure and the care needs of patients. The men indicated that this sense of professional responsibility also included managing the health care encounter to meet patient needs. Then these PHCPs were meeting their role obligations as the service providers – and the patients were not required to assume unreasonable responsibility for managing either the diagnosis or treatment of their problem, or the relationship itself.

We get an insight to the impact of professional responsibility on these participants' trust experiences in Brent's description of Dr Scott, the doctor who finally had taken responsibility for him following his diving accident. Brent called this man the "consummate professional" (M#3:1587), partly because he had taken full professional responsibility for Brent after a number of other

PHCPS that same day had not been able or prepared to. R. responded: "Yeah. It was almost like finally there was someone who was doing the job and you weren't having to do it for them".

- **Person-ability.** This refers to the practitioner's professional ability to engage meaningfully with each of the day's patients as a separate individual and acknowledges the skill required for a PHCP to sustain this relational practice over long periods of time. It is a key building block for the 'Personal Connection' detailed earlier, commonly found in PHCPs whom these patients experienced as "personable" (e.g., Brent's Dr Scott, M#3:335).
- **Efficiency.** Yet another construct that the participants all seemed to understand well; they used it easily without needing to define or discuss it as a collective in order to reach a common understanding. 'Efficiency' was constructed by these men on the PHCPs' intelligent and measured use of resources, predominantly time, within the health care context. This efficiency could be practised among health care staff, evident then to the participant in their teamwork. At other times, participants experienced efficiency more personally as a PHCP practice skill dynamic within the patient-practitioner relationship.

Both senses of efficiency are apparent in R.'s following individual narrative:

R. was immediately impressed with the staff who quickly took his details and got a doctor to examine him straight away...Within half an hour his X-rays were taken and again he was dealt with in an extremely skillful, friendly, and efficient manner...By the time he walked out of the clinic, probably only some two hours or so after having walked in, R. marveled at the professionalism and speed with which he had

been looked after. The place seemed to run with clockwork precision... (R., M#3:361)

PHCP efficiency was lived as a sign of professional respect for The Man, who like the practitioner, had a place in the world and a life to get on with, and whose resources likewise were to be respected:

When we [male patients] do go along and we've got a 15 minutes slot, we are looking at the 15 minutes just as much as the doctor is looking at the 15 minutes. In fact we get even more agitated because we've already sat in the waiting room for half an hour to get in and use his time and that's our time as well. Because, you know, we've come from work or whatever and so we need to get back to work and, hey, this is holding us up to get back there (Brent, M#2:1806).

PHCP behaviours and responses that were perceived by the men to be wasting their time or money had immediate detrimental effects on their trust in the practitioner (Collective, M#4:1956).

However, at times a PHCP could be perceived as being too professional: *"Jimmy can be very down to earth at times...and Jimmy still doesn't have the feeling with his current doctor that he can share something that even mildly transgresses the barriers that you set in courtesy and politeness"* (M#2:1681). His doctor's professionalism was lived by Jimmy as a personal constraint on his relational behaviour, which therefore limited their relationship. Instances when the participants experienced a lack of professionalism in their PHCPs, or an infringement of expected professional practice standards, similarly had a negative effect on their trust in the practitioners.

Dave's first individual narrative, about his initial visit to a naturopath, prompted the collective to explore just how extensive the damage triggered by a single breach of professionalism could be. A drama student at the time, Dave had gone along to this practitioner on a personal recommendation, for help with tiredness and listlessness

and with “great hopes that here is someone who will at last tie together all the various strands of his own past attempts to be thoroughly healthy” (M#1:1400). The naturopath gave Dave a full body massage,

finishing by placing one hand on top of Dave's head and the other on a point below his stomach, holding this position for a minute or two. Then out of the blue comes the statement that takes Dave completely by surprise.

“I have noticed that your penis seems unusually coloured. It has almost a yellowy-grey tone to it. I think you're not getting a good blood flow because of a blockage in your sexual chakra. I can do a treatment that will focus on this for you. It involves massaging your prostate gland by inserting a finger into your rectum. Is that alright?” “Um...Ah, yeah. OK.” This is [Dave's emphasis] an unexpected development.

Oddly enough, however, Dave'd made a similar observation himself a few days earlier, but had just put it down to not having had any real interest in sex for the past few months. He couldn't remember the last time he'd masturbated or even had an erection. There certainly hadn't been the opportunity – or time – for any development on the romantic front. The fact was, Dave had been feeling somewhat depressed for a while.

Graham inserts his finger fully into Dave's rectum to massage his prostate gland. Dave doesn't notice anything out of the ordinary while this is happening, and only a little discomfort. If anything, he feels 'numb'.

He notices that Graham doesn't put a glove on before starting the treatment. After a couple of minutes, Graham removes his finger and wipes it on the towel. This time, Dave thinks to himself: “What? Not washing? Well, I guess he's saying there's nothing unnatural or unhealthy about that part of the body.” Using the same finger, Graham then commences to massage in a deep circular motion, a couple of inches below Dave's navel. Almost immediately Dave begins to feel sexual energy building up in his groin like a slowly spreading fire, and realises that he's starting to get an erection. He feels surprised by this – a bit pleased, but also a little bit embarrassed. He's not sure what to say, and so decides to keep 'undergoing the treatment'. Part of the difficulty is...it's damn pleasurable.

This goes on for a further few minutes, until Dave finds that he's rapidly approaching the point of orgasm. He realises that he really doesn't want this to happen. He doesn't want to

ejaculate in front of a near stranger, whether or not the treatment is meant to improve his sexual functioning. Just as he is about to say to Graham "That's enough thanks," Graham stops and Dave's rapidly arising orgasm subsides.

"You'll find that your sexual energy will be a much greater driving force for you in your creative work and life," Graham says. "Would you like a cup of herb tea? I'll let you get dressed and then we'll sort you out a meal plan." As Dave is dressing, Graham goes to the kitchen and writes out by hand a macrobiotic diet involving, from what he can recall, brown rice, fish, seaweed and chicken.

Then returns to the lounge with the tea and they sit to talk for another ten minutes or so. Graham tells Dave how he is a Buddhist, that he's running a retreat in a couple of weeks time and that he feels that Dave would benefit greatly from coming to it. Dave says he will give it some thought. Graham then asks him if he's missing any of the ingredients in the diet list, before going back out to his kitchen to make up a parcel for Dave of various things from his own pantry.

"I understand that you're a poor student and some of these things are a little pricey. Look you don't owe me anything for this session. It would be good to see you at the retreat if you're able to make it." Dave thought it over for a few days but in the end he didn't go. He felt that meeting up with Graham would be awkward somehow. In fact, saying thanks and goodbye was the last time he spoke with him. (M#1:1421)

During the ensuing analysis Dave described feeling "taken advantage of" by the PHCP at a time when he was insecure and depressed. Dave was convinced that, as a consequence of his decision to trust this man and speak openly to him, the practitioner had been fully aware that Dave was "struggling emotionally and socially" and very vulnerable. The other participants, who had detected subtle emotion changes in both Dave's written text and his reading of it, encouraged Dave who declared finally an overriding feeling of "indignation" at the morally complicated but ultimately "undignified situation" he had found himself in.

Together, Dave and the other members of the group, made sense of the practitioner's behaviour by understanding it as "unprofessional" (M#1:1685), a term which the men did not qualify and which used alone somehow failed to express the profound implications of the experience for Dave. That Dave had only ever spoken to one other person about this incident was a better indication of its significance in his life.

In this case, the "unprofessional" behaviour of the practitioner entirely destroyed the patient's trust.

Dave: ...Dave had liked the person he'd been speaking to. There was quite a lot of trust there. In the waiting room he'd been quite trusting – I think he used the word 'womblike', like it was a safe environment.

Brent: Yeah. 'Dark but warm'. And you described him as 'kind and warm and good humoured'.

R.: Yeah. There was a lot of trust up to that point. (M#1:1657)

Dave recounted feeling "numb" during the incident, and was silent for years afterwards. However, after he had written the individual narrative and just hours before coming to the group Memory Work session, Dave wrote down his reflections on the incident and finally made sense of the incident for himself – "*I've had this breakthrough this afternoon*". Then, towards the end of the collective analysis on his individual narrative, he was able to declare: "*I think it is clear in this situation that the relationship of trust was broken completely*" (M#1:1760).

'Care' or Psychosocial PHCP Responses

In which the mechanic talks to The Man about exactly what's wrong with the car and what the repair options entail, giving details about the estimated cost and time

involved for each option. The mechanic is up front and points out the pros and cons as he sees them for The Man's situation. The Man talks through the options out loud, the mechanic making comments occasionally.

As perceived by the men involved in this research, this set of PHCP responses relates to the more subjective or expressive dimension of the relationship, in particular to PHCP relational skills and personal qualities that influenced the quality of the patient-practitioner interaction overall, and the patients' subsequent experiences of trust. Throughout their research the men themselves repeatedly distinguished two general categories of PHCP responses that correspond to cure and care. The PHCP's "knowledge and expertise" (Brent, M#3:2632) – the cure responses and abilities – were enough to develop and sustain The Man's "trust in the technical ability" (Jimmy, M#5:406) of the practitioner. But it was the PHCP's care abilities that enabled the much deeper patient trust these men experienced, and distinguished it from competence-based trust. The following quotes convey a sense of the participants' general understanding of PHCP 'care' abilities:

"That's been a common theme throughout, hasn't it – it's not so much what the GP is saying, it's more the how [R.'s emphasis] they say it. It boils down to the good old bedside manner" (R., M#2:1633).

"Gaining the [patient's] trust in the way they do their things" (Jimmy, M#3:2347).

"We're talking interpersonal skills as opposed to trust in the therapy" (Brent, M#5:404).

"It's trust with him as a person" (R., M#5:444).

Thus, according to Gronroos's theoretical framework for services (1984), these care responses relate to the 'how' of service delivery, or the way in which the health care service is performed. (The previous subsection on those PHCP 'cure' responses integral to the men's trust experiences was focussed on the theoretical 'what' of the service, or its technical dimension.) Specifically, the following attitudes, personal characteristics, and relational behaviours of the PHCP are the 'care' responses perceived by this group of men to be crucial to deep patient trust as they lived the phenomenon.

Theme 7: Empathy

Like the women, the male participants used the term 'empathy' often and easily throughout their work on trust. Within the first two hours of their work together (out of the total 15 hours group work) this group of men was exploring the possibility that empathy was the single, most important element of patient trust as they had experienced it

Brent: We actually look for that personal relationship with our health care provider as somebody who empathises with us more than anything else...so maybe it's really about a personal relationship that we set out to establish early.

R.: Yeah. When you made that point it seems to me that a couple of the words that you used there were absolutely spot on for me because, like you say, a major part of the trust...came from not even being fixed ['cured'] by Jan [PHCP] but just the feeling of being cared for, and having somebody who was actually understanding, and somebody who showed concern for this problem, and really wanted to help me to find some sort of resolution, even though she couldn't. (M#1:903)

Involvement

Personal involvement by the PHCP was the key element in the men's common-sense of 'empathy'. Involvement was also key in the women's construction of empathy, although they paired PHCP involvement with a certain degree of emotional detachment as equally important in their experience.

PHCP empathy, according to the men's construction, was a combination of care responses to the individual patient, which included a "reaching out" to the patient (R., M#4:2023), a "real understanding" of (1) the patient as a person (R., M#4: 2024), (2) the effect the health problem was having on the participant as an individual (R., M#4:1842), and (3) the impact of ill-health on his life (Brent, M#2:1300). Thus, empathy was one more response-ability located in the PHCP, which facilitated a closer personal relationship with the participant as a separate individual.

Emotional Involvement

Although emotional involvement with the patient was a vital to the men's notion of 'empathy', emotion per se did not seem to figure as largely in the experience for the men as it did for the women. The women were quite clear that there were limits to the nature and the amount of emotional involvement that were acceptable in PHCP empathy – too much emotion, for instance, and the experience was perceived as sympathy or 'emotional baggage' rather than as empathy. Interestingly, the men made no such delineation.

Indeed, the men's narratives suggested that instead of relational problems triggered by inappropriate or too much emotional involvement by the PHCP, they commonly faced relational problems caused by lack of emotional involvement by the practitioner. Too much emotion from the PHCP had not had any part in the health care experiences the participants brought to this research. Perhaps, because of their gender they were less likely to experience difficulties of inappropriate emotional involvement within their relationships with male PHCPs (same gender relationships were predominant and preferred by these participants); whereas because the women dealt more regularly with male PHCPs they were more likely to experience involvement problems. This hypothesis also helps support the preference many women have for consulting women PHCPs. Or, perhaps these men took it for granted that the limits of emotional involvement by the practitioner would be clearly defined in the professional prescriptions for the role of PHCP.

Whatever the explanation for the apparent gender differences in the construction of 'PHCP empathy', there was a much smaller and less developed emotional component in the overall construct for the male participants. The dominant common sense to their construct was that of the practitioner identifying fully with the patient in his experience of ill-health, and the wider implications for life. In this form, the men valued PHCP empathy highly in their patient-practitioner relationships and collectively named empathy as a vital practitioner response in developing and sustaining patient trust.

Theme 8: Friendliness

This category brings together all those personal qualities and relational abilities of the PHCP that make the practitioner 'friendly', and easy for the patient to use. Brent experienced "friendly" in a GP who was "interested in Brent as a person and what life has for him. He wanted to know as much about Brent as he could on this first visit, and he related quickly through issues of fitness and professionalism and work" (M#2:1320).

Warmth and Good Humour

Over their research the collective built up a profile of the 'friendly' practitioner, constructed on the two subsidiary qualities of warmth and good humour. Dave 'named' these qualities together in his description of a PHCP whom he subsequently decided was trustworthy: *"And Graham seems to Dave to be the right person for the job. He seems a kind man who is warm and good-humoured"* (M#1:1402). Later on in the research, Dave identified these as the very qualities which distinguished his new and trusted GP from his previous doctor, the family GP who had been at the centre of a particularly negative experience of trust: *"There was a warmth and friendliness and...joking, you know, joking with the patient"* (M#3:892). Brent too declared warmth as one of the distinguishing traits in his current GP, a practitioner he now trusts enough "to go and jump off a cliff for" (M#1:900). This PHCP conveyed warmth during Brent's first visit to him: in the way he related physically to Brent "sitting in an open situation, fronting up to Brent rather than behind a desk" (M#2:1329), as well as in the way he managed their verbal exchange, chatting socially

“about life and family and politics, rugby, exercise, all sorts of issues” (M#2:1331) before getting onto the health reason for the visit.

Good humour, as a quality in the PHCP, worked to help the participants relax in the health care context and to create a bond between the practitioner and the patient. A good-humoured practitioner gave the patient the impression that he enjoyed the job (Dave, M#2:1907), told the patient stories – “often funny stories” (Brent, M#3:2534), joked with the patient (Brent, M#2:1338), and generally was able to “lighten the situation” for The Man (Dave, M#3:2561). For these men the value of good humoured PHCPs lay not in their punch-lines, but in the over-riding “feeling of friendliness in the rapport that it [their humour] leads to” (R., M#3:2551).

Finally, friendly PHCPs were also described as “nice” (Brent, M#4:2555), “decent” (R., M#5:513), and “easy-going” (Brent, M#5:2359). In contrast, PHCPs who were seen as lacking friendliness were experienced as “a robot doing the prescribing” (Dave, M#2:1908) and an “impersonal body mechanic” (Dave, M#5:1128).

Participants found it impossible to connect person-to-person with such practitioners. There was no room in the relationship space for them as real people; they were only able to Be there as ‘patient’, behaving and responding according to the prescriptions laid down in the traditional role-description.

Theme 9: ‘Reading’ Skills

Another of the PHCP-centred characteristics common to the participants’ positive trust experiences was the practitioner’s ability to “read” the patient (Jimmy, M#2:1676). This notion of the PHCP’s ‘reading’ ability was developed by the

collective as a construct to make sense of the practitioner's skill in perceiving how the patient was experiencing the health problem and its implications for his way of life. Their sense of 'reading' also included the practitioner's skill to discern (and almost anticipate) the patient's individual health care needs, based on his way of being unhealthy.

Insofar as this care aspect related to customer needs and wants in the health care context, 'reading' was similar to the women's construct of PHCP responsiveness. Whereas 'responsiveness' was concerned with the practitioner's reaction to meeting the woman's needs and wants, 'reading' skills were concerned more with ascertaining what exactly was happening for the male patient and thus being able to identify what his needs and wants were likely to be, given the individual's situation. On a simple linear plane, if responsiveness were towards the outcome end of the relational processes occurring around patient needs and wants, reading skills would be at the other end, the beginning of the continuum.

Perceptiveness, Listening and Comprehension Skills

'Reading' a patient required sensitivity (R., M#4:1850, 2403), a keen perceptiveness (Brent, M#2:2676), good listening skills (R., M#4:2433), the ability to detect and decipher cues in the patient's behaviour/demeanour/story (Jimmy, M#4:2467), and comprehension skills for a firm grasp of where The Man was at (R., M#4:2461). There are parallels between these skills needed by the PHCP for reading patients, and the skills required to develop as an accurate and fluent reader of written language - decoding and encoding, auditory skills, reading in context for full meaning (J.

Fitzgerald, personal communication, December 14, 2003; M. Singers, personal communication, December 13, 2003).

Once the PHCP had finished this initial stage of reading the patient, and had made an informed judgement on the patient's position relative to the health problem – had a fix on where the patient was at (R., M#4:2400) – then the PHCP was able to astutely match the various cure and care elements of the health care service to the patient. Throughout treatment the PHCP needed to re-read the patient to check the fit; reading was thus a cyclical process – read, comprehend, match, respond, re-read, and so on. Rather than forcing patients “to fit into a standard model of how a consultation should go” (Dave, M#4:2189), practitioners who were perceived as good readers were usually experienced as flexible and adaptive in their technical and relational responses to patients. These PHCPS were able to adapt their health care service to fit the individual circumstances and needs of each person who came to them for help (R., M#2:592, 577). And so, the practitioner's reading ability was itself ‘read’ by these participants as another indicator of PHCP trustworthiness (Jimmy, M#5:1265).

Theme 10: Honesty

Prognosis

PHCP honesty, as perceived by the patient, was extremely important to trust for these men. It was a critical factor in the women's experiences of patient trust also. For the men, honesty's most obvious form was basic verbal truth-telling by practitioners; for instance, informing the patient fully about his health condition, admitting that they

had limited knowledge or experience with a condition (Brent, M#3:2395), or answering patient questions truthfully. However, the participants also perceived 'honesty' in more subtle forms in certain other relational behaviours.

Practitioners who were comfortable 'researching' (going to other sources for more information) in front of the patient were regarded as honest and realistic about their own personal capabilities:

"He [PHCP] declared his difficulties as a GP trying to make sense of all the medical issues and the many sources to access for new information" (Brent, M#2:1333).

"Not trying to be God but just trying to be a real person and saying... 'This is what I think it is, I'll just back it up with...'" (Jimmy, M#2:1529).

"It's not necessarily having all the answers..." (R., M#2:1534).

Openness

Openness in the PHCP also indicated honesty, as perceived by these participants. An open, up-front manner in the practitioner (e.g., Brent, M#2:1324) was evidence of personal truthfulness – no facades, no hidden agendas. Openness enabled the patient to 'meet' the real person the PHCP was and to connect with that person: "Trust is affected by the actual person...whether or not you feel as though you get on with them as a person" (R., M#5:1712). Moreover, such openness in the PHCP encouraged the patient, in turn, to respond with honesty:

Jimmy: They're not playing God.

Brent: No.

Jimmy: And they're basically making it comfortable enough for us to open up and say whatever you may want to say...Just not [relating] in that patronising manner. Not condescending or patronising...

R.: And being generally focussed on you.

Dave: Yeah. Able to say 'Look, I need to check a reference on this', or, you know, 'I need to get a book to go and find something out...'

Jimmy: Yeah. Not by saying 'I'm God. I know all'. And 'Look at the certificate on the wall'...[but] getting comfortable before you start talking about...what's happening for you.

Brent: Guys aren't used to sharing those sorts of things, are they?

R.: No.

Brent: They maybe share them with their wife, but actually sharing them with another male is a challenge to the old comfort zone. (M#2:2586)

During a collective analysis of the links between honesty and patient trust, Dave explained that he felt safe with a practitioner who related to him in an open manner; in contrast with “being made to feel small or ignorant or just not really explaining things thoroughly, like ‘It’s nothing you really need to know about’. And you feel vulnerable in that situation. You want to be in a situation where you can be respected” (M#2:1926). This comment indicated that PHCP honesty was experienced as a sign of respect for him as an individual, a signal to the patient that his vulnerability would not be exploited, his self-esteem was safe in the context of the patient-practitioner relationship.

Genuineness

PHCP honesty was also inferred from the patient's sense of the practitioner's sincerity or genuineness, using The Man's “built-in bullshit radar” (R. & Jimmy, M#5:1721). Practitioners who were “down-to-earth” (Brent, M#2:1335) in their manner and related as a human being to these men were likewise regarded as trustworthy. These very human qualities, and the phrases used to express them, heighten the distinction lived by these men between “I am God” PHCPs (Jimmy, M#5:529) and those with

their feet on terra firma. (The question begging to be asked at this point is: Do men find it difficult to trust God?) These aspects of the men's trust experiences relate back to the importance of a personal connection between patient and practitioner, and also point to issues around relational power within the patient-practitioner relationship. These power issues will be discussed in this chapter within Theme 12: Trust as Alliance, and expanded in Chapter 8.

* * *

Deconstructing the practitioner-related dimensions of the men's trust experiences into PHCP 'cure' aspects (Diagnosis and Treatment Skills, and Professionalism) and PHCP 'care' aspects (Empathy, Friendliness, 'Reading' Skills, and Honesty), reveals important connections between aspects within this 'Other' domain, and between aspects from this and the 'He' domain. For instance, the analysis highlights links between the practitioner's reading skills and empathy to the patient's fundamental need for a personal connection with his PHCP. Of course, in real life the men lived these aspects as interlinked, dynamic and complex experiences of patient trust. The men themselves used various hermeneutic devices to make some overall sense of their relational experiences with PHCPs; for example the car metaphor, and the analogies of the ladder of trust and the bucket of trust.

The male participants used two "factors" to help them understand and appraise specifically PHCP-related aspects in their trust experiences. Both factors operated across their health care encounters and relationships as they unfolded, enabling the men to link critical relational aspects together for a more meaningful sense of the

patient-practitioner interaction as a whole. At a much more specific level, these factors also enabled the participants to 'bench-mark' PHCP performance and so evaluate whether or not the practitioner was measuring up as a trustworthy service provider.

The Two Factors 'X' and 'Quack'

The X Factor

The men used the X Factor construct to understand and explain that rather enigmatic combination of esoteric personal qualities in the PHCP that "made them a bloody good human being" (R., M#5:2832). Jimmy referred to the men's car metaphor to try to explain the special nature of these PHCP qualities: "It's like a car. You quite often hear that somebody [e.g., a mechanic] can hear something's wrong with the car. He's fantastic – he 'feels' the car, kind of thing" (M#3:2354). These "ultra personality" (R., M#5:1712) qualities, which the men found difficult to articulate or define, were critical to their experiences of patient trust: "*The one that is right at the centre of all of [the elements of patient trust] is the X Factor*" (R., M#5:2830). Indeed, the collective indicated that this X Factor was the key for patients to the highest level of trust experiences with practitioners (M#5:2817).

These vital PHCP qualities ranged across the 'care' aspects predominantly – empathy, friendliness, warmth, openness, genuineness and sincerity, honesty – but as implied in the men's discussion of their appraisals of whether or not the PHCP was "a decent

guy” (R., M#5:513) also took account of the practitioner’s personal code of ethics, or “that person’s level of integrity and moral fibre” (R., M#5:2810).

Capturing these qualities within the X Factor enabled the participants to comprehend some of the difficult relational dynamics involving intuition, gut feelings, and bonding that their data revealed were integral to deep patient trust. Finally, the X Factor provided the men with a “measuring stick” (R., M#4:2252), of sorts, with which they could evaluate the performance of individual practitioners and measure the quality of the relationship as a whole. The X Factor construct was embedded in the collective’s analysis of the men’s most positive trust experiences.

The Quack Factor

The Quack Factor afforded participants a different overview of practitioner-related responses with regard to trust in the context of the patient-practitioner relationship. Rooted in their negative experiences of trust, this “in-built quack detector” (R., M#4:2165) also accounted for very subjective feelings individual participants experienced, but this time in relation to PHCP responses that they perceived as indicators of untrustworthiness in the practitioner.

The Quack Factor constructed by these men was constructed mainly around practitioners who were seen to be “pretending to be...doctor[s]” (Jimmy, M#4:1361) and ripping off patients as a means for personal financial gain, “simply there to take your money” (R., M#4:1328). Within these general situations, the men applied the Quack Factor specifically to perceived incompetence in the PHCP (Brent, M#4:1364),

practitioners working outside the traditional boundaries of bio-medical health care (Dave, M#4:1381), PHCPs who “talked a load of rubbish” (Brent, M#1:178), crazy practitioners (Dave, M#4:1390), practitioners who processed patients without individualising their treatment to fit the patient (Jimmy, M#4:1941), over-reliance on technology and/or lack of interpersonal skills (Brent, M#4:908), and poor health care value for patient money (R., M#4:1547). The collective located at the centre of these situations a quack/practitioner who was to varying degrees exploiting The Man’s vulnerability (M#4:1379).

‘X Factor’ and ‘Quack Factor’ were both labels that the participants themselves used during their group work. It is interesting to reflect on their choice of the word ‘factor’, a science term, in a construct they employed to explain and measure some extremely subjective dimensions of the trust phenomenon as they experienced it. By using these two ‘factors’ the men were effectively able to capture and contain aspects of their trust experience that by nature are fluid, fuzzy, hard to comprehend, and difficult to control.

7.5 Patient and Primary Health Care Practitioner Together as ‘They’

In which The Man and the mechanic decide what needs to be done to the car. They’ve gone over the repair options, talked about the advantages and disadvantages of each. Now they decide on the best option - given the circumstances. The Man leaves the workshop and the mechanic carries out the repairs on the car. When the car is ready The Man returns, discusses the repair job with the mechanic, pays, and drives away.

Within the relational heuristic, 'They' refers to the relationship itself between the male patient He and the PHCP as Other, or their interaction together. In this section we examine those facets of trust that these men lived in relation to the relationship as a whole, rather than those aspects of trust that they experienced or perceived were focussed on either the patient or the practitioner as an individual. Instead, this domain of the heuristic provides the analytical space in which to explore those relational facets that relate to the interactional dynamics or synergy created by the patient and practitioner in relationship.

This section thus presents the facets of the trust phenomenon that the male participants understood related to 'They', the patient-practitioner relationship itself. In the last chapter we saw that the women constructed three themes that made sense of the 'They' facets of their patient trust experiences: mutual reciprocity between patient and PHCP, trust as a sense of safety within the patient-practitioner relationship, and the empowerment they experienced in the atmosphere of trust. For the male participants the 'They' facets of their patient trust came together in two themes, the first called Reciprocity and the second 'Alliance'. The latter label follows the men's use of the word 'ally' in their work, and their allusion to the construct of alliance as a particular way of being in relationship with another.

At the end of the classification of the men's data, this section of the relational heuristic contained the fewest number of categories and entries within those categories. Overall the 'They' domain was much lighter than those of Male Patient as 'He' and PHCP as 'Other' were. The themes of Reciprocity and Alliance together

indicated that these men made sense of patient trust mainly in reference to themselves or to their practitioners as individuals.

The relatively low number of entries in this domain strengthened a deep understanding that had been growing in me over the period I was analysing the men's data, that it had been very important for these participants that they maintain their identity as separate human beings within their patient-practitioner relationships. A computer search of the men's transcripts for words like 'team', 'partner', and 'together' provided more support for this understanding. None of these words was ever used by these men to describe or explain their relationship (including their trust experiences, positive and/or negative) with their PHCPs. Rather, for these men, the 'They' facet of patient trust was experienced more as a collaboration of the two separate agents, patient and practitioner, each doing his own job within the context of the relationship. Inherent in the men's construction of 'They' was embedded yet another intriguing paradox: the key to unlocking the Gestalt of patient trust for these men was found in the very separateness of the two agents creating the health care relationship.

Theme 11: Reciprocity

This set of features of patient trust developed by the collective centred on a give-and-take dynamic that operated within their patient-practitioner relationships and contributed to the sense of transaction conveyed by many of their trust experiences. For these men reciprocity was lived on the basis of the principle of give-and-take in the interaction between the patient and the practitioner. This relational practice could be initiated by either the practitioner or the patient. For example, Brent perceived that

his GP set up their consultation for mutual personal exchange by "...actually sharing some of himself first, so that in return he might get something back from Brent again" (Brent, M#2:1427).

Willingness and Effort

Common to many of the men's negative experiences of trust was a perception that the patient was doing all of the 'giving' in the relationship and not getting enough back in return from the practitioner, and that his attempts to establish a mutual interchange based on reciprocity were "brushed off" (Brent, M#5:2025) by the practitioner. Key then to this theme of Reciprocity was the perceived willingness by the practitioner both to relate to the patient as a person (e.g., Dave, M#2:999), and to make the effort required to sustain a relationship with him (e.g., Jimmy, M#2:512). In the absence of this willingness a relationship could be seen as being very one-sided:

It seems to me that R.'s doing all the work. R.'s doing the research, R.'s doing the paying, R.'s doing the attending, R.'s doing the communication. Mr Field, on the other hand – by what I read – is not doing the same, you know, giving the same back to the relationship. (Brent, M#5:538)

In relationships where the reciprocity dynamic was operating, the men reported that they were happy to share information with their PHCPs, and to forgive or overlook "the odd indiscretion" by the PHCP (R., M#5:2825). They detailed an attitude of basic reasonableness or fairness, which they had toward their trusted practitioners. This attitude lay beneath the willingness of patients to give the PHCP the "the benefit of the doubt on an off day, on a bad hair day" (R., M#5:2820), and "the time to prove his worth and at least try and make some changes" (Brent, M#1:546). In return, the men

expected these same sorts of relational behaviours and attitudes toward them from their PHCPs.

Respect

This relational reciprocity was linked also to a mutual respect between patient and practitioner, which was important to trust: "...the actual respect has to built between both of you [practitioner and patient]...He's got to earn it and you've got to be prepared to work with him" (Jimmy, M#5:2855). R. laughingly suggested that this mutual respect could represent "the 'r' in the word 'trust'" (M#5:2861).

Theme 12: Alliance

Their fullest, most positive experiences of trust were lived relationally by these men as a particular type of alliance with PHCPs. These trusted practitioners were perceived as being on the same side as the men, united with the men in an alliance conferred for the purpose of dealing to the patients' health concerns (M#4:2668). In these positive experiences of trust then the participants felt that the PHCP was firmly "on his side" (R., M#3:848) and that like the patient, the practitioner also regarded the man's health problems as the primary purpose of the relationship. Individuals who felt as though they were part of such an alliance described feeling relaxed (Brent, M#3:334) and reassured (Dave, M#2:559), losing their previous fear and/or anxiety (e.g., Brent, M#3:1731).

Further, in the following excerpt Dave expressed an anticipation almost, that he felt at going along to see his trusted family GP during the mental health crisis which had developed around an act of civil disobedience:

He [Dave] hadn't seen Dr S. for at least four years, but was pleased to be going to him. As they drove there, Dave resolved to tell him everything. It would be good to have an ally, someone who could stand alongside him and explain the situation to the police...(M#3:167)

At this point in the narrative then Dave was looking forward to working with this man as an ally, but he was to find during the ensuing encounter that the doctor instead had made an alliance with his father. His realisation that the doctor had shifted his allegiance marked the point at which Dave's trust in that particular GP began to break down (Dave, M#3:570).

Brent too offered a telling insight into alliance and non-alliance relationships when he contrasted his trust experiences with two PHCPs who had treated him after his diving accident. The first practitioner, whom Brent had not trusted and to whom he referred as the "little bastard" (M#3:1542), had "jammed" a drain through Brent's left ribcage into a collapsed lung. The second PHCP, whom Brent called the "consummate professional" (M#3:1587) and to whom he literally entrusted his life, was technically thorough and assured, as well as personable and respectful. This practitioner, who had demonstrated throughout the crisis that Brent's well-being was his primary focus, was perceived by Brent to be working in league with him, collaborating with him in order to accurately diagnose and treat the critical health problem.

Agency

At the very centre of the men's experience of alliance as a key facet to patient trust was the notion of agency. From the Latin verb *agere* to act, 'agency' as it is used here refers simultaneously to being active and to exerting power. Within the patient-practitioner relationship, 'agency' is related to both the patient and the PHCP, specifically to their ability to act and remain in their power as individuals while in relationship – it is this sense of distinct agency that is acknowledged in the men's theme of alliance. Two human beings collaborate in a common interest (patient's well-being) without losing any part of themselves in the relationship: thus the Man is able to maintain his sense of Self and stand alongside the practitioner as an agent in his own right.

According to the common-sense of the patient-practitioner relationship held by these men then, the patient and the PHCP occupied separate (albeit collaborative) positions in the relationship, and each had different jobs to do relative to the mutual goal of "improving the situation" of the patient (Dave, M#4:2668). This separateness was conveyed convincingly in the men's frequent reference (27 times altogether) to 'the job' of the PHCP, a term that implied a clear set of tasks and responsibilities expected of the practitioner. Individual participants spoke about the practitioner "doing the job" (e.g., R., M#3:1593), and underscored the differentiation between the separate jobs of patient and of practitioner in phrases such as "I felt that it wasn't my job to have to know how to pitch the sessions..." (R., M#4:2181).

All of the participants used the 'job' term, either in their individual narratives and/or during collective discussion. The notion appeared to be another taken-for-granted, well-understood construct for these men. During this research the collective did not negotiate a definition or detailed description of the job of either the PHCP or the individual male as patient, which suggested that this construct too was a familiar one in their everyday interpretations of patient-practitioner relations. The collective also discussed "boundary lines" that separated the patient and the practitioner, another phrase that conveyed well-demarcated and well-contained jobs for each (M#4:1061, 1513).

Equality

'Agency', as it was lived by the participants, was reflected a number of ways in the men's data, notably in their perception of themselves as equals with the PHCPs in their relationships of deep trust. In these relationships the men related to the practitioners as human beings – they did not make gods of them and subsequently there were no power issues in their positive trust experiences. These practitioners were perceived as "just trying to be real people [rather than] trying to be God" (Jimmy, M#2:1529). And when practitioners presented as human beings, the patient worked beside them as a fellow human being, an equal (e.g., Brent, M#3:327).

At the heart of the participants' construction of equality and agency was their understanding of themselves as the holders of specialised knowledge. Just as PHCPs held expert technical knowledge that was necessary to deal with the patient's health care issues, so too these patients perceived that they held valuable personal

knowledge that was equally important – ‘expert’ knowledge about The Man’s body, his way of life, the influences on his health, his health history, his family health history, and so on. In their negative experiences of trust the men gave this knowledge to the practitioner begrudgingly (e.g., R., M#4:1837), only in part (e.g., Jimmy, M#4:2233), or deliberately withheld it (e.g., Brent, M#4:978). The group also explored several occasions when personal information was given by the patient but which the PHCP subsequently ignored (e.g., Brent, M#4:2210; Jimmy, M#5:2014) or dismissed (e.g., Dave, M#5:1171). In contrast, in positive relational trust experiences the participants shared their expert knowledge readily, often voluntarily, with PHCPs (e.g., Jimmy, M#2:2048; Brent, M#3:318), just as these practitioners shared their expert technical and/or scientific knowledge with their patients (e.g., Dave, M#4:113; Jimmy, M#4:1656).

The relational dynamics of reciprocity helped set the base for patient-practitioner alliances, in which patient agency and equality were common aspects of the patients’ way of Being in relation to the PHCP. In the environment of such alliances (i.e. the ‘They’ of this heuristic), patient trust flourished. In short, these men’s deepest relational trust was experienced with PHCPs they related to as allies.

7.6 Concluding Comments

From the perspective of these men, trust in a PHCP was a phenomenon of degree or scale, “not an on/off switch” (R., M#5:763) but something that increased or decreased according to the patient's perception of the practitioner's professional and relational behaviours. Trust was not easy. These participants revealed that they were often suspicious of PHCPs and slow to trust them. They believed that their trust had to be earned by the practitioners, in the competence and care they demonstrated in interaction with the patient.

The relational heuristic enabled us to deconstruct the trust experiences of these men into three different domains. They created the four themes of Risk, Evidence, Autonomy, and Personal Connection to make sense of their trust experiences at the individual or ‘He’ level. The six themes Diagnosis and Treatment Skills, Professionalism, Empathy, Friendliness, ‘Reading’ Skills, and Honesty accounted for the aspects of their trust experiences that the men perceived were located in the practitioner at the ‘Other’ level. At the third level of ‘They’, these men used the themes of Reciprocity and Trust as Alliance to help interpret their trust within patient-practitioner relationships. This group made it clear that getting ‘fixed’ was the overarching purpose of the relationship; outcomes of trust such as compliance, commitment, and empowerment were mentioned by individuals but not developed into major themes by the collective. The themes and important aspects of those themes that the men used to make sense of their experiences of trust are summarised in Table 2: Themes and Aspects of Trust in the Men's Experiences.

Table 2: Themes and Aspects of Trust in the Men’s Experiences

Domain		Theme	Aspects
Patient as ‘He’		1. Perceived Risk 2. Evidence 3. Autonomy 4. Personal Connection	Vulnerability Proof of PHCP trustworthiness Proof of Progress Proof of treatment Physical evidence Money Self determination Knowledge Voice Evaluation by patient Self-control Patient’s best interests Patient as person Patient’s life context Professional intimacy Rapport Individualised health care
PHCP as ‘Other’	Cure	5. Clinical Skills 6. Professionalism	Accuracy Thoroughness Also: technical skill, competence, expertise, experience ‘Personal’ characteristics: confidence, independence Practise skills: confidentiality, credibility, knowledge-ability, response-ability, person-ability, efficiency
	Care	7. Empathy 8. Friendliness 9. ‘Reading’ Skills 10. Honesty	Involvement Emotional involvement Warmth Good humour Perceptiveness Listening skills Comprehension skills Prognosis Openness Genuineness
Patient & PHCP as ‘They’		11. Reciprocity 12. Alliance	Willingness Effort Respect Agency Equality

The themes reported in this chapter represent shared elements and patterns of patient trust as lived by the men who took part in this research. These elements and patterns were interpreted variously and configured differently by each man according to the specific health care situation he was in, relative to such factors as his individual needs and/or his state of health at any one point in time, and the particular practitioner with whom he was interacting. Elements were thus awarded different salience and priority by different men in similar situations, and by the same man in different patient-practitioner encounters. For example, Personal Connection was very important for R. in his relationship with Jan, an alternative therapist, but less critical in his trust experiences with Dr Field, a medical practitioner he saw later on for treatment for the same condition. These individual variations in how the men arranged and interpreted the trust themes are to be expected – as humans they are by nature complex, adaptive beings. Trust between two complex human beings, the man and his PHCP, reflects the complexity of both human beings in a dynamic health care relationship. The commonalities and differences revealed by this data reflect the complexity of the phenomenon as it occurred in real life for the participants.

On another level differences between the men indicated that the men's Car Metaphor might not be as useful today as it has been in the past. It does not allow for such dimensions to The Man's health as spirituality, an aspect that Brent and Dave separately identified as important in their personal understanding of overall well-being (Dave, M#1:1981; Brent, M#2:1290). Also, according to the metaphor The Man gets out of the car and leaves it with the mechanic to fix, symbolically detaching himself from his health problem; this plot-line does not allow for any emotional

responses The Man might have to deterioration in his health. The data of this research thus reveals that the metaphor does not stretch to fit the full range of health care encounters of today's patients and the discourses they use to make sense of their health experiences.

The next chapter will discuss the similarities and differences between the trust experiences of the women and of the men who took part in this research, and present the theories that the participants themselves used to account for their experiences. From this basis, the chapter will also draw on a range of academic theories to develop new insights to patient trust as it was experienced by these female and male participants in their relationships with primary health care practitioners.

7.7 In My Own Words

It was during this chapter I noticed that there is no longer any music in my house. Looking back, I realise that it stopped some time ago, in the Women's Chapter I think. And my daughter and I haven't danced together for a while either. This is heady stuff. I felt the women's data as intense. I feel the men's quite differently – it requires all my concentration to step into their shoes – and then keep them on for any useful length of time. My lessons are to do with empathy and compassion and acceptance. I've had to work hard at them.

Reading Fox's "A Spirituality Named Compassion" helped me understand that I was putting into practice principles of 'bracketing', a term I had first encountered in my methodological reading years ago and assumed was an activity understood and practiced by a select few at agreed upon times. Like Morris dancing. Wondered at the

difficulty I was having entering into and holding onto the men's ways of making sense of their experiences - I had to face an urge I had to explain away their 'realities' almost dismissively. Can understand that this might be a product of domestic circumstance, and age (attitudinal remnant of First Wave feminism?).

But I've done some reflecting also on what seems to be an insidious gender-bashing that is still operating within contemporary New Zealand society, and maybe within certain academic cultures as well, that pits men against women in some sort of trumped-up competition where the victories are always hollow. Am also aware that the post-modern drive to celebrate difference at the cost of shared aspects of our lives represents another philosophical extreme for me personally. Celebration of difference allows us to exercise our respect for another human being; celebration of common experience allows us to connect.

I look forward to playing music again and ballroom dancing in the kitchen with my daughter – I hope she hasn't grown out of it in the meantime.

Also experienced some methodological tension between the post-modern call to abandon the stereotypes constructed around gender and the need to report the sophisticated traditional stereotyping systems that underlie the trust experiences of these participants. "You've got to do it," my Dad told me. "To stay faithful to the data." Remember now too, the academic street wisdom that the theoretical 'ideal' is generally two decades ahead of life on the street. (Chagrin.)

November 13 2003. Our beautiful little boy, Zachary, dies during labour. My first grandchild.

8: Theorising the Women's and Men's Experiences of Trust in Primary Health Care Practitioners

“The wanting to trust is one of the biggest scary things...” (Jimmy, M#5:1449).

8.1 Introduction

The previous two chapters detailed the themes that the women and the men participants used to make sense of their trust in their primary health care practitioners (PHCPs). Both chapters followed a descriptive agenda, describing and explaining the phenomenon of trust as these participants lived it and the constructions they used to make sense of their trust experiences within various primary health care contexts. This chapter presents a series of tables that identifies the similarities and differences between the trust themes used by the women and the men taking part in this research. In order to fulfill the potential of the research data, this chapter follows a theoretical agenda to explore the theoretical links between gender and those experiential themes.

The aim therefore of this chapter is to tie the findings of the research to overarching theoretical propositions that can account for the ‘how’ and ‘why’ of the phenomenon of trust in PHCPs as it was experienced by these women and men. The “inferential glue” (Miles & Huberman, 1984, p.228) that supports the move from the participants’

empirical data to a more abstract theoretical framework comes from several sources. It incorporates the theories that the women and men themselves used to help structure their interpretations of their trust experiences. Their theorising runs alongside academic wisdom, notably theories of social construction, gender, consumer behaviour, services marketing, and relationship marketing, to deepen our understanding of the links between gender and patient trust.

The social constructionism perspective highlights the subjective nature of health and illness; the meanings of these states and experiences are known and interpreted through social interaction and thus definitions and understandings vary across time and culture (e.g., Germov, 1998; Lupton, 1994; Turner, 2000). Social constructionism theory, which supports the understanding that health and illness experiences are historically and socially situated, challenges researchers to explore “taken-for-granted features of the present” (Lupton, 1994, p. 15) by interweaving historical, cultural, and social patterns into our interpretation. Gender is one such pattern, acknowledged to be a significant dimension both of social difference in contemporary Western society and of our experience of health and illness (e.g., Broom, 1998; Germov, 1998). See Chapter 3: Concepts and Connections for a discussion of social constructionism as it is applied to health and an overview of gender theory.

This research focuses on the interaction of gender, or the behaviours and roles participants live as ‘masculine’ and ‘feminine’ (Hacking, 1999), with their experiences specifically of patient trust at the microsocial level, within their relationships with PHCPs. This chapter discusses the interplay between gender and patient trust from the starting point of the participants’ experiences, the meanings and

understandings they use to account for gender-trust dynamics, and extends their theorising by considering the historical, cultural, and social forces that might have helped shape these constructions of patient trust.

Setting the summaries of the women's trust themes alongside those of the men (Tables 1 and 2 from Chapters 6 and 7 respectively) enables us to discern those themes that may be held in common between these two groups, those themes that share elements, and those themes that are specific to either the group of women or the group of men taking part in this research. Discussion of these commonalities and differences will focus on patterns that occur at the level of the major themes.

However, the constituent aspects of the trust themes also are presented in the tables to enable the reader to appreciate how the genders configure each theme. While this discussion will draw attention to some of the more interesting patterns within and across the constituent aspects, it is beyond the scope of this thesis to discuss all those patterns to the same depth.

8.2 Common Trust Themes

There are five major themes held in common by the women and the men of this research. These themes, which overlap considerably, are Personal Connection, PHCP's Clinical Skills, Empathy, Honesty, and Reciprocity. These are constituted as major themes by both genders. The first of these common themes, Personal Connection, is lived by the women in the PHCP in the Other domain of their trust experiences, and by the men in the He domain. This illustrates the point that although these two groups might hold a trust theme in common, they nevertheless can organise

it differently within the overall relational framework they use to make sense of their experiences. The women and the men live the remaining four trust themes within the same domains of their experiences. All participants thus live PHCP's Clinical Skills, Empathy, and Honesty within the 'PHCP as Other' domain, with PHCP's Clinical Skills a 'Cure' dimension, and Empathy and Honesty relating to the 'Care' dimension of the practitioners' service delivery. The fifth common trust theme, Reciprocity, is lived within the 'They' domain by both genders. However, while the women and the men hold these five themes in common, there are also subtle differences in how they construct each of the themes. These differences are revealed within the aspects of each theme, as shown overleaf in Table 3: Common Themes in the Participants' Experiences of Trust in PHCPs.

Table 3: Common Themes in the Participants’ Experiences of Trust in PHCPs

Theme	Aspects	
	Women	Men
Personal Connection	Patient’s life context Patient’s best interests Listening skills PHCP intuition (‘Other’)	Patient as a person Patient’s life context Professional intimacy Rapport Individualised health care (‘He’)
Clinical Skills	Accuracy Appropriate treatment (‘Other’)	Accuracy Thoroughness Also: Technical skill, competence, expertise, experience (‘Other’)
Empathy	Professional caring Involvement Emotional detachment Compassion (‘Other’)	Involvement Emotional involvement (‘Other’)
Honesty	Prognosis Respect (‘Other’)	Prognosis Openness Genuineness (‘Other’)
Reciprocity	Trust Honesty Respect Partnership (‘They’)	Willingness Effort (‘They’)

Personal Connection

This theme seems to encapsulate the patients’ lived experience of the ‘patient focus’ advocated by health care researchers and practitioners. Although it is common to the women and the men of this research, Personal Connection is organised within their total trust experiences slightly differently. The women position it at the ‘PHCP as

Other' level of the relational heuristic, and the male participants focus it on the individual patient within the 'He' domain. This suggests that these women focus on personal connection more as a relational response that they recognise in the practitioner, and the male participants construct it more relative to self. This could be said to be in line with gender theorists who propose that a focus on the other in relationship and interdependence are feminine ways of thinking (e.g., Gilligan, 1982, 1995), and a concern with self and a 'separate knowing' within relationship are elements of a traditionally masculine perspective (e.g., Belenky, Clinchy, Goldberger, & Tarule, 1986).

That they construct a theme out of personal connection, however, indicates that in the context of their health care relationships these men have overridden the norms of traditional masculinity to some extent. The importance these men place on deep personal interaction in this theme can be seen to move beyond the boundaries of conventional masculinity, which endorses separateness and objectivity (Cameron & Bernardes, 1998; Jordan, 1997a; Kosta, 1994) for males, and be founded more in the participants' shared experiences of basic humanness than in gender.

Central to this theme for both the women and the men is their experience of personal involvement or engagement by PHCPs, present moment attentiveness, and an understanding of the unique, individual qualities of the patient as person and the life context in which she/he is living ill-health. In the Personal Connection theme(s) we are able to see the need in these patients for practitioners to acknowledge their differentness, with the practitioners relating, seemingly paradoxically, from a

connection point of sameness or shared humanness – connecting with the patient, one human being to another.

At the broadest macro-level, the need for connection is regarded as a basic human need (e.g., Jordan, 1997b; Leininger, 1978; Montgomery, 1993; Walsh, 1999), necessary because of our inherent vulnerability as a species for the health of society and the survival of humankind. Extending this theorising, in the micro-context of the patient-practitioner relationship this basic human need is intensified by the patients' need for specialised human assistance and interdependence at a time when they might be feeling particularly alone and vulnerable because of their health condition. There is ample support in the nursing literature for the participants' focus on Personal Connection as a theme within their patient trust experiences. For example, Montgomery comments:

While these qualities [of health care situations characterised by crisis, trauma, suffering, loss, and death] are most apparent in acute and emergent care settings, they are to some degree present in any situation in which clients feel vulnerable...where trust does not have the opportunity to develop over time, but seems to be replaced by a need to be instantaneously connected, due to the patient's vulnerability...trust seems to be an immediate survival instinct (1993, p. 77).

According to theorists such as Montgomery, a personal connection with the practitioner helps patients negotiate situations when they must place considerable trust in another person. For example, medical sociologist Lupton (1996) argues that:

...trust relations in the [patient-practitioner] relationship are always characterised by ambivalence, uncertainty, anxiety and a sense of risk because this relationship characteristically involves a high level of vulnerability and dependency...It is not only the body that is revealed to doctors and other health care workers in quite exclusive ways...they are also privy to patients' confessions of private thoughts and feelings which patients may never reveal to others... (p. 167).

The participants' emphasis in this theme on their innermost feelings, their life-world contexts, and the understanding by practitioners of them as individual human beings underline the ways in which health care relationships differ from other professional services offered by a 'provider' to a 'customer'/'consumer'. Customers of financial advisers or lawyers do not usually want nor are required to share as intimately with these providers as happens with PHCPs. The subject matter between patient and practitioner is highly personal, the subject matter is 'embodied' in the person of the patient, as it were. On the other hand, the subject matter between a financial adviser and customer is more removed from the client's actual person, and has more of an external focus. A deep personal connection emerges then as a distinguishing characteristic both of 'good' patient-practitioner relationships and of the trust which is experienced within that service context.

Across their health care narratives and analyses these participants used words like "bond", "intimacy", "reaching out", "profound", "whole person", "spiritual", "intuition", and of course, "connection" in their descriptions and explanations of their relationships with practitioners. These words indicate a relational depth not well explored or understood in the marketing literature, or even in the relationship marketing literature. Without these dimensions we can have only a partial understanding of human 'relationship', and risk therefore trying to relate meaningfully to human beings we dehumanise as 'customers' or consumers', labels which relegate them to the position of Object in the relationship, instead of Subject: an It instead of a Thou in Buber's (1958) scheme of human relatedness. (See Jordan, 1997b for a discussion of object relations theory.)

Nursing researchers, on the other hand, have been examining and theorising the nature of patient-practitioner relationships for several decades now. Integrated in this body of knowledge is a well-developed theoretical understanding of the deep emotional, spiritual, and relational dimensions to health care relationships, along with the social, psychological and physical dimensions that are theorised by other disciplines (for excellent overviews of these latter theoretical approaches see Currer & Stacey, 1986; Dew & Kirkman, 2002; Oakley, 1993; Samson, 1999). Nursing literature therefore offers valuable theoretical insight to the experiences of these participants who identify so clearly the importance of personal connection to patient trust.

Finally, extending the theoretical standpoints discussed above to this research, we see that it is possible that the theme Personal Connection is common to the women and the men by virtue of their shared humanity and position as 'patient' in these primary health care relationships, and therefore transcends gender at this more abstract level of theme. However, when we unwrap the theme we do find differences in the ways the women and the men construct it. As discussed in the previous two chapters, these differences in the experience and configuration of these constituent aspects of Personal Connection do reflect gender to varying degrees.

PHCP Clinical Skills

The second of these common trust themes, PHCP Clinical Skills, relates to the practitioners' skills in diagnosis and treatment and thus to the primary purpose of the patient-practitioner relationship: "dealing with" the patient's health care problem as Jane put it (W#4:1465), or getting "fixed" as R. referred to it (M#1:501). These are

patients' terms for the "technical solution" (Gronroos, 1990, p.16), theorised in services marketing literature as the minimum expectation that customers have of service providers (Gabbott & Hogg, 1998; Zeithaml et al., 1990). This is in line with the importance of competence to trust theorised by Andaleeb (1992). In the health care context the clinical skills of the practitioners are critical to their ability to meet this minimum expectation of patients that they will deal to, or solve, their health care problems.

Insights to the theme of Clinical Skills afforded by role theory confirm the importance of clinical skills in the health care context. Role theory as it is applied within services marketing (e.g., Bitner, Booms, and Mohr, 1994), allows us to understand that the 'job' of practitioners, so clearly articulated by the men, is reflected in the set of expectations that the patients have for certain role behaviours from the service providers. The traditional biomedical patient-practitioner relationship has been particularly well-defined over the years. Just as these participants understand that much of their behaviour in the health care context is expected to conform to the role prescribed them as patients, they can also have very well-developed ideas of what practitioners, medical practitioners in particular, are 'supposed' to do.

So, in situations when these women and men regard the primary role of their practitioner to be a technician-fixer of their health care problems, clinical skills are taken for granted and become assumed within the set of role expectations they learn and adopt for the practitioner. Gaps perceived by the patients between their expectations of service providers and various aspects of the service are theorised to cause disconfirmation and lead to customer dis/satisfaction and changes in perceived

service quality. This is supported by disconfirmation theory and the gap model (Oliver, 1980, 1993; Zeithaml, Parasuraman, & Berry, 1990) in the marketing literature. Thus, lack of the clinical skills patients expect of practitioners can be understood to lead to dissatisfaction in general, and/or to decreases in trust specifically.

Within the wider context of primary health care services in general, the patients' expectation for a technical solution to health problems is linked directly both to the concept of core product (Lovelock, Patterson, & Walker, 1998) and to that of the "fundamental promise" (Gabbott & Hogg, 1998, p.110) inherent in services, that the service provider will do what he undertakes to do. Without the requisite clinical skills that represent the core product of health care providers it is impossible for PHCPs to fulfill this promise. In effect, the promise is broken.

These services marketing concepts provide a means of understanding the importance of clinical skills to patient trust across genders in terms of roles, expectations, and promises. The theme Clinical Skills relates to the core clinical competencies that these participants, in the role of 'patient' (a genderless social position), expect of the providers of health care in their role of 'practitioner'. Trust develops when health care providers have the clinical skills that patients expect and that enable them to keep their 'promise' to customers, regardless of gender. Conversely, trust founders when practitioners lack those core clinical skills and the promise to the patient, which is implicit in their professional position, is broken.

Empathy and Honesty

The third and fourth common trust themes, Empathy and Honesty, relate to the 'care' aspects of health care service (as discussed in Chapter 3) and are therefore located within the 'Care' dimension of the relational heuristic used to frame the participants' data. Services marketing theorists posit this overall 'care' dimension of the service experience as the process of service delivery. In other words, the care dimension is the means by which the provider delivers the cure, the fundamental expectation of the service.

In health care services, where the patients as customers frequently do not have the experience or knowledge to evaluate the quality of the core 'cure' component, then they use 'care' aspects as surrogate indicators both of cure and of service quality (Gabbott & Hogg, 1998). Their data indicates that these participants also use surrogate cues specifically for the trustworthiness of the PHCP. Particularly in the early stages of the patient-practitioner relationship, patients often do not 'know' the PHCP personally and have not yet experienced trust in that individual. Faced with these relational conditions it seems reasonable that these participants use cues as to the trustworthiness of the Other. Following the theorising that accounts for the care-cure surrogacy, it is plausible that Empathy and Honesty are two familiar and easy-to-identify 'care' aspects that health care consumers across both genders employ to help them understand the more relationally complex phenomenon of trust.

It is interesting to note that the functional perspective of some services marketing theorising (generally based on Shostack's 1977 molecular model of the service

product) positions the technical cure aspect at the core or centre of the health care service experience, with care as peripheral or process aspects. It can be argued that this perspective within the marketing literature follows the scientific positivist orientation that characterises the traditional bio-medical model of illness based on the mechanical view of the universe and the separation of mind from the body. Just as the traditional bio-medical model is criticised for its emphasis on cure and its neglect of the human side of health and healing (Montgomery, 1993), so too this marketing perspective on the relation of care to cure can be challenged for failing to account adequately for the subjective nature of health. Such a perspective simply does not allow for the primacy of care in patients' health care experiences.

Nursing literature offers a theoretical base for developing a different understanding of the links between cure and care aspects, and their relation to patient trust. Care and caring are central concepts in the theory and practice of nursing (e.g., Dyson, 1999; Gadow, 1988; Leininger, 1984; Morse, 1990; Quinn, 1989; Watson, 1988). These and other nursing theorists and practitioners who validate the subjective nature of health and healing, recognise the importance of care and feeling cared for and the links to patients' physiological healing processes, and set the relational care skills needed to sustain successful professional relationships squarely alongside the science and technical skills required for cure. This conceptual positioning challenges the traditional reification of cure within the biomedical model of health care, and calls into question other conceptual frameworks that privilege the technical over the relational.

Moreover, it is also in line with the lived experience of the participants in this research who reveal that care aspects are integral to their understanding of trust within patient-practitioner relationships. The women and the men identify Empathy and Honesty along with cure-focussed Clinical Skills as equally important facets of patient trust at the thematic level. The nursing literature supports their organisation of these facets into separate themes with equal intrinsic value.

One of the shared assumptions upon which contemporary nursing has developed its theory on caring holds that caring is a natural human condition, a relational involvement and responsiveness triggered by another's vulnerability (e.g., Montgomery, 1993; Noddings, 1984). Given the inherent vulnerability of health care patients (constructed as a theme by the women and as a thematic aspect by the men, and discussed at a conceptual level in Chapter 2: Putting Health Care into Context), the nursing literature indicates then that the trust themes of Empathy and Honesty are specific PHCP care responses common to these participants because of their shared humanness and their shared position as 'patient'. (This basis for commonality is the same as that theorised for the women's and men's themes of Personal Connection.) I will now discuss separately the themes of Empathy and Honesty to explore more deeply the links between gender and these facets of patient trust.

Empathy

Empathy is a fundamental concept in nursing's caring literature, commonly used to understand the practitioner's role in a health care relationship (e.g., Montgomery, 1993; Morse, Anderson, Botter, Yonge, Obrien, & Solberg, 1992; Reynolds & Scott,

1999). This supports the participants' development of Empathy as a trust theme focussed on the relational responses and behaviours of the PHCPs. At a very general level, empathy names a deep appreciation by one person of another person's subjective experience in order that s/he can understand what the other is feeling. Remaining at this general level of theorising, these women and men identify empathy as a distinguishing characteristic of PHCPs – these patients need and value empathy from PHCPs in health care situations where they are typically very vulnerable. At this level, Empathy crosses gender. However, below this there are some important differences within the women's and men's constructions of the Empathy theme.

The women's group highlighted a certain emotional detachment in their PHCPs; in contrast, these men identified a deep level of emotional involvement that they experienced in their patient trust. The 'history' of medical domination and abuse of female patients indicates that women patients are more likely than men to experience transgressions of the patient-practitioner relationship by the PHCP, and subsequent betrayals of patient trust. Therefore it is reasonable to suggest that these female patients have learned to distrust what they regard as inappropriate empathy from a practitioner; instead their trust experiences are characterised by an empathy that has a significant objective component to it and maintains a certain amount of relational distance between patient and practitioner.

On the other hand, the men's Empathy theme has a distinctive subjectivity to it – there are two plausible explanations for this. First, these men do not go to a PHCP for help unless "there is something really really wrong" (Brent, M#2:1785), reflected in Jimmy's comment: "...of course being the typical male Jimmy doesn't go there unless

he is dying” M#2: 1760). So, it is likely that when they finally do get into the consultation room their health condition is serious and/or they feel particularly vulnerable. It is not surprising that a PHCP who shows empathy for the patient is perceived by these men as a reassuring, safe, trustworthy individual to be talking to. This finds support in the construct of ‘psychological safety’ theorised by Andaleeb (1992) as integral to trust.

Second, given that it was common for these men not to develop long-term relationships with specific health care providers until middle age, their history of health care consumption to that point tended to be of one-off visits on a ‘needs must’ basis. As these men theorised the consumption pattern of young men, these visits were typically straightforward health problems requiring a mechanical fix and little (if any) relational trust. It is possible that patients who repeatedly experience minimal emotional involvement with their PHCP in this type of encounter learn to expect that practitioners will relate from a distance. Disconfirmation theory (Oliver, 1980) supports the proposition that a patient socialised to expect little empathy from the service provider is going to be surprised and delighted when he does experience it, and that empathy will stand out as an important feature of the relationship.

Honesty

For both genders, the fourth common trust theme, Honesty, has two main dimensions to it. The first dimension relates to objective realities about an individual's health care condition, the truth about her/his illness, treatment, and prognosis in general. This dimension focuses on the available scientific/technical information around a particular

condition, and the practitioner's sharing of that information with the individual as patient. From the patient's perspective, these technical details represent part of the knowledge base that endorse the practitioner's position as an 'expert' and the patient's position of vulnerability (Lupton, 1996); honest sharing of these details indicates then that the practitioner is choosing not to misuse this latent power. PHCP honesty at this level is linked directly to the patient's right to know the truth regarding her/his health condition. This is at the same time a patient-as-consumer right (Lupton, 1997; Samson, 1999) and a fundamental human right (Bishop & Scudder, 1985; Chauhan & Long, 2000). Both rights apply across gender.

The second dimension to Honesty relates to the more subjective and emotional truths that the individual experience as part of her/his condition. This second dimension focuses on the full meaning and implications of the condition for the person in the context of her/his life, the personal truth of the situation for the individual, and the practitioner's active participation in helping the individual to understand/experience that truth. This sense of honesty does not appear to have been explored in the marketing literature. In the nursing literature, however, scholars Chauhan and Long (2000) hold that honesty and truth-telling are critical to sustaining "valuable human interaction", and therefore "fundamental to being ethical or moral" (p. 981). This subjective dimension to honesty affirms the individual as a person. It distinguishes her/him from objects and thus signals a way of relating in which the practitioner is treating the person as a valued human being (Buber's 'I-thou' relation) rather than as an object ('I-it') (Gadow, 1985; Chauhan & Long, 2000). PHCP honesty at this level thus involves the basic rights of these women and men as human beings, and therefore

challenges theorists and practitioners to address wider issues of human ethics implicit in the patient-practitioner relationship.

The women drew attention to the connection between honesty and respect for them as persons. Marketing scholars theorise links between honesty, respect, and trust (e.g., Friman, Garling, Millett, & Mattsson, 2002; Ganesan, 1994; Kumar, Scheer, & Steenkamp, 1995) but do not illuminate the subjective aspects of these trust facets. For the men, the openness and the genuineness of the practitioner were particularly important aspects of PHCP honesty at this subjective level, focuses well-supported in the nursing literature (e.g., Chaucan & Long, 2000; Montgomery, 1993). This intersubjective dimension to honesty requires the PHCP to step out over any line drawn to separate practitioner from patient and relate one human being to another, regardless of prescribed social roles (e.g., patient, gender) and expectations.

Reciprocity

The fourth and last of the trust themes common to both the women and the men of this research is Reciprocity. This theme concerns a dynamic lived by the participants in the patient-practitioner relationship itself, reflected in both genders locating it within the 'They' domain of the relational heuristic. The term 'give and take' that participants used to express their perceptions of relational reciprocity refers to the balance they sensed in the relationship, and signals their perception that the practitioner was willing to actively participate in building the relationship. Nursing theory holds that this reciprocity creates an equality between the patient and practitioner that is grounded in a shared humanness and heightens the feeling of

connectedness between the two persons (Montgomery, 1993, Watson, 1989). This deep intersubjectivity theorised and advocated in contemporary nursing literature, represents yet another significant challenge to the dominant, biomedical model for the patient-practitioner relationship. Patient-practitioner relatedness, deep emotional involvement, connection on the basis of shared humanity - all are strikingly different from the professional distance PHCPs traditionally have been advised to maintain from their patients (Hardey, 1998; Lupton, 2000), and which is easily recognised in many of the participants' negative experiences of patient trust. These facets to trust are also absent from much of the marketing literature on trust.

Social psychology holds that reciprocity typically occurs at the highest level of personal relationship when some degree of "real personal involvement and intimacy" exists between the partners (Forgas, 1985, p. 226). Relationships develop to this level due to such factors as self-disclosure and emotional involvement (among others). In the health care context it is these same factors that differentiate patient-practitioner relationships in which participants experience deeper relational trust from those supporting competence-based patient trust. Often, relationships in which patients experience deeper trust develop considerably faster than general personal relationships between friends and/or loved ones. In the interests of efficiency and accurate diagnosis patients find they need to disclose intimate information about themselves almost immediately in the patient-practitioner relationship, whereas this level of intimacy is reached at a later developmental stage in personal relationships (Durkin, 1995; Forgas, 1985). Thus, reciprocity might well develop faster in patient-practitioner relationships than in social relationships, if it develops at all.

This research reveals that reciprocity is lived slightly differently by these women and men. The women's group construct the theme around their experiences of trust in the PHCP 'begetting' trust in the patient, honesty begetting honesty, respect begetting respect, and so on. Their theme, which largely took shape during collective reflection and analysis, contains an element of surprise, almost as though reciprocity is not expected, its occurrence and value recognised after the event. These men however, indicate that they go into relationship expecting reciprocity as a basic relational norm of interpersonal exchange.

Despite these nuanced differences in their experiences however, both genders live reciprocity as a distinctive movement between the individuals in a relationship that is integral to the construction of deep patient trust. This is in line with the work of scholars from various disciplines who theorise that reciprocity reflects the common preference of human beings regardless of gender for balanced relationships in which individuals relate on the level of shared humanness (e.g., Forgas, 1985; Watson, 1989). Reciprocity is a way of relating that underscores the mutual participation of both patient and practitioner in the construction of deep patient trust and highlights its social and relational dimensions. It is a trust theme that appears to be common to both the women and the men, on the basis of shared humanity and common ways of doing relationships, but is not well developed in the relationship marketing literature on trust.

In addition to the common trust themes represented in Table 3, there are four constituent aspects from the remaining themes that are common to the women and the men taking part in this research. These shared aspects are Listening, Life Context,

Involvement, and Individualised Care. For details of how these two groups configured these aspects in their constructions of patient trust please refer to Tables 1 and 2 at the end of Chapters 6 and 7 respectively.

8.3 Shared Trust Themes

Certain facets of patient trust are shared by the women and the men but are configured as a major theme by one gender and as a constituent aspect by the other. A total of nine trust facets are shared by the female and male participants, and therefore make up a set of themes that partially overlap between these two groups. These shared trust facets are presented in Table 4: Shared Facets in the Participants’ Experiences of Trust in PHCPs.

Table 4: Shared Facets in the Participants’ Experiences of Trust in PHCPs

Theme	Aspect
<u>Women</u> Vulnerability (‘She’) Knowledge (‘She’) Voice (‘She’) Responsiveness (‘Other’) Professional Confidence (‘Other’) Thoroughness (‘Other’)	<u>Men</u> in Risk (‘He’) in Autonomy (‘He’) in Autonomy (‘He’) in Professionalism (‘Other’) in Professionalism (‘Other’) in Clinical Skills (‘Other’)
<u>Men</u> Perceived Risk (‘He’) Professionalism (‘Other’) ‘Reading’ Skills (‘Other’)	<u>Women</u> in Vulnerability (‘She’) in Professional Confidence (‘Other’) and Empathy (‘Other’) In Personal Connection (‘Other’)

It is important to note that these shared facets involve only two of the three domains of the relational heuristic. All apply either to the 'She/He' domain or to the 'Other' domain; none relates to the 'They' domain. All the shared facets therefore concern either one or the other of the two separate individuals comprising the patient-practitioner relationship: she or he as the patient, or the PHCP as the other person. The overlap thus is composed of facets of trust that these participants centre (albeit at different levels) on the identifiable single selves in the relationship, which leads us to sharpen the focus of our theorising on the positions the individuals occupy and how s/he makes meaning of their interaction. The relationship itself, the Gestalt of the two individuals, their relatedness or interdependence, is not represented here. Themes within the 'They' domain are either common to both genders (e.g., Reciprocity) or gendered, (e.g., the theme of Safety, constructed by the women and not by the men). There is no degree of overlap between the genders' themes from the 'They' domain.

In addition, although each of these shared facets has a different salience according to gender, Table 4 illustrates that the women and men do locate each facet within the same relational domain. For example, the women live Vulnerability as major theme at the 'She' level of the patient-practitioner relationship; the men also locate Vulnerability within their 'He' domain but experience it as a subsidiary aspect of the major theme Risk.

These patterns in Table 4 suggest that the two genders share a set of trust facets, but that in their construction of patient trust they configure these differently by gender. The facets are likely to be shared because they are universal human ways of living trust, or because the participants all are in the position of 'patient' in the health care

context (as discussed fully in the previous section of this chapter). The following discussion theorises how and under what conditions gender interacts with the configuration of these trust facets.

Vulnerability

Patients, by the very fact that they need help, are in a position of vulnerability. Its salience in the participants' experiences of trust supports the work of contemporary marketing theorists Singh and Sirdeshmukh (2000) who hold such vulnerability is the main driver of trust in credence-based services. But this research takes this somewhat mechanistic appreciation of vulnerability to a different level. The participants' descriptions and analyses of vulnerability lead to insights to the emotionality of vulnerability, and some strong interactions with the social processes of gender.

In the context of the patient-practitioner relationship, vulnerability can be exploited (e.g., when the PHCP exercises power over the patient) or alleviated (e.g., when the PHCP is committed to sharing power within the relationship). This vulnerability can be heightened for patients under the biomedical model, which dehumanises patients in general, awards power to the practitioner and prescribes obeisance and compliance for the patient, regardless of gender. The women refer to this in the following excerpts:

Melissa: That socialisation thing – you've been brought up to believe that doctors know all...

Emma: ...know best. Yeah. And you don't question them, you just go along with what they say. (W#3: 510).

Jane: Our generation was taught to respect and obey (W#3: 3027).

Amy: That's what's engrained, you know, 'They [PHCPs] are powerful and you need to succumb to them'. (W#3: 2991).

Finally, the biomedical model, recognised as a patriarchal organisation (e.g., Broom, 1998), is charged with further oppressing women patients in particular on the grounds of their femaleness, viewing them as problematic and dangerous, biologically disordered relative to men:

For centuries women have traditionally been defined as the Other in medical discourse, the 'sick' or incomplete version of men: as weaker, unstable, the source of infection, impure, the carriers of venereal disease or the source of psychological damage to their children (Lupton, 1994, p. 132).

This biomedical view of femaleness was rooted firmly in the patriarchy that has shaped modern Western culture and which assigns women a subordinate position to men (Hardey, 1998; Lupton, 1994). An ideology in which gender is constructed around systems of hierarchy, ranking, binary oppositions, and power and control, patriarchy privileges men:

by taking the male body as the 'standard' and fashioning upon it a plethora of valued characteristics (health, mastery, rationality, reason, and so on) and, through a comparison, constructing the female body as deficient, associated with illness, with lack of control and with intuitive rather than reasoned action (Annandale, 1998, p. 63).

While it has been actively challenged and deconstructed by feminist theorists since the 1950s, patriarchy nevertheless remains a recognisable ideological force in Western society today (see Dew & Kirkman, 2002, and King, 2003, for discussions of patriarchy in contemporary New Zealand), experienced in the health care encounters of the women research participants and evident in their theorising:

Emma:...we could hear Dr Carter next door. He was dictaphoning notes to his secretary. And I can still remember the way he was talking into the dictaphone, he just sounded like a pompous git....so offhand and so patronising about 'Oh

this woman has got no problem and it's all in her head'...(W#4: 1964).

And also:

Louise: ...his [the dentist] behaviour was just awful.

Jane: Dis-respectful?

Louise: No it was worse than that. It was...I felt as though he was so pissed off and then trying to make me feel like ...

Emma: ...guilty.

Louise: Yes. Guilty that I had caused it.

Melissa: So you think it was maybe the same - 'Stupid woman. What's she here for? There's really nothing wrong'? (W#4:2716)

The vulnerability inherent in the position of patient thus is heightened further for these women by the undercurrents of patriarchy that ran through their socialisation and persist in contemporary health care (Annandale, 1998; Bunkle, 1988; McLennan, Ryan, & Spoonley, 2000; Waitzkin, 1991). The women recognise how their vulnerability as female patients can be intensified and perpetuated in relationship patterns between patients and PHCPs:

Louise: We take, excuse me, we take some shit and we keep our mouths closed.

Melissa: But that to a certain extent is why it happens.

Louise: So it keeps on happening...

Melissa: Because every body keeps their mouths shut.

Emma: It becomes a vicious circle basically.

Melissa: It does become a vicious circle because nothing happens and those of us who do say something just get labelled. 'Here comes the bitch from hell again'.

Emma: Yes. Or 'Here is that stroppy woman'. (W#4: 2897).

Finally, the problem of sexual abuse in the patient-practitioner relationship adds another layer to the vulnerability experienced by these women. In the last few years there have been several high-profile cases of sexual abuse of patients in New Zealand. For example, in 2000 Christchurch doctor and deputy mayor Morgan Fahey was struck off the medical register, and jailed for six years on 11 admitted charges of rape, sexual violation, and indecent assault of women who were his patients. In the aftermath of this case, the New Zealand Medical Council and the New Zealand Medical Association both revised their policies on appropriate sexual boundaries between patients and practitioners.

“Patients are always vulnerable and the relationship with the doctor is not equal. Trust is utterly essential,” commented Medical Council president Dr Tony Baird at the time (New Zealand Herald, 2001, p. A8). The new code of ethics for medical practitioners, adopted in 2002, states that “Exploitation of any patient, whether it be physical, sexual, emotional or financial, is unacceptable and the trust embodied in the doctor-patient relationship must be respected” (Waikato Times, 2002, p. 8).

Then, in yet another high profile New Zealand case in 2003, psychologist Richard Aukett was struck off the register by the Psychologists Board after having sex with a female patient whom he was counseling, and whose former partner he was counseling at the same time. As the issue of sexual abuse by practitioners is brought to public notice it is understandable that women become increasingly aware of their sexual vulnerability in their health care relationships and of the risk that sexual boundaries might be breached at any time (Women's Health Watch, 2001).

In their patient-practitioner relationships vulnerability can be an intense, complicated experience (refer back to Chapter 6). Seen in the light of the wider context of these women's lives, patient vulnerability reflects and supports broader social processes and relations that occur around gender. These processes of gender add layers of complexity to the patient vulnerability lived by these women and help to explain why it is that the female participants experience it as a major theme in their health care encounters, rather than as a constituent aspect to another theme. On the other hand, the male participants configure vulnerability as a subsidiary aspect of their patient trust. Vulnerability appears in their interpretative work as a constituent aspect of the major theme Risk. There is theoretical support in the gender literature for the construction by men of vulnerability as a risk. It is generally agreed that the traditional masculine ethos 'teaches' men from an early age to be self-sufficient, self-reliant, and stoic; conversely, being vulnerable and asking for help are regarded as not acceptable (Goodyear-Smith & Birks, 2003; Kaplan & Marks, 1995; North Health, 1996; Tudiver & Talbot, 1999). Vulnerability can put at risk their concept of masculine self.

The male participants make numerous references throughout their research to these teachings in their lives:

"We're all do-it-yourself guys, aren't we? ...We've got this little niggle somewhere and we can all find the reason for having that niggle, like 'It was the lifting I did on Friday afternoon'. I know what the niggle is, so it will go away." (Brent, M#5:2081). "As guys we tend to leave it [the health problem] and leave it until it'll fix itself, or go away, or whatever" (Brent, M#2:631).

"He felt that if he'd started to cry the GP would have been disgusted or disapproving of it. He wouldn't have been sympathetic" (Dave, M#3:703).

Jimmy:...you're heavily socialised from your parents...that 'man' thing...you remember your father putting up with this

and the other for weeks on end before he would go to the doctor...

R.: You used to get a medal for putting up with things, didn't you.

Brent: Got rewarded for it

R.: Yeah. That's right – you did. You used to get your uncle and aunty passing comments about what a good lad you were.

Jimmy: Yeah, well, I remember...one Christmas Grandfather saw my father ironing a shirt [and said to him] 'Men don't iron'.

Brent: I remember as a kid when I broke my arm that...the comfort was: 'Oh, you're brave – you're not crying, you're standing up to it'. It wasn't like 'Bawl your eyes out because it must be bloody hurting' (M#5:2936).

Jimmy refers to the difficulties that these prescriptions can mean for the individual male in his quote, which opens this chapter: “The wanting to trust is one of the biggest scary things...” (M#5:1449). Jimmy implies that wanting to trust and the dependence on another it involves goes against the self-sufficiency and control that he has been brought up to believe is the ‘right’ way to be a man.

Theorists believe that particular characteristics of traditional masculinity help to account for men's reluctance to go for help to health care practitioners (Arndt, 1996; Doyal, 2001; Tudiver & Talbot, 1999). In particular, in the face of an ethos that lauds the masculine invulnerability associated with being the protector/provider and personal qualities such as control and taking charge, toughness, confidence and self-reliance, admitting a problem and seeking help can be regarded as unmanly, both by the individual and by his peers (Cameron & Bernardes, 2000; Goodyear-Smith & Birks, 2003; Kaplan & Marks, 1995). Coupled with the difficulties around vulnerability are what researchers identify as men's socialised fear of intimacy (Levant, 1995), and their inability to identify and talk about their emotions (Cameron & Bernardes, 2000; Levant, 1995).

The international research into the links between masculinity and patterns of health care is reflected in New Zealand research. North Health's discussion document on men's health holds that here in New Zealand the social construction of masculinity leads men to "ignore symptoms, trying to 'tough it out' and generally not wanting to look weak" (1996, p. 6). It warns that "It is easy to underestimate the power of this 'masculinist' outlook and we may have an especially strong version of it in New Zealand" (ibid). Deeper insights to this last comment are found in the work of New Zealand historian Michael King, who refers to "the 'man alone' ideal, the hunting-shooting-fishing ethic and the solitary bachelor" and... "the highly practical do-it-yourself tradition" in his discussion of the Kiwi identity (2003, p.507). The men themselves make a strong connection between attitudes to illness and Kiwi masculinity:

Jimmy: A couple of times...I've felt lousy but I know I'm going to get better – 'It's just a cold that's been going around that everybody else has got'.

Brent: Get into bed, take a Panadol, and drink a bit of water and you'll come right.

Jimmy: Yes. That's it.

Brent: It's that good old pioneering spirit again, isn't it. If something breaks you go and fix it. Kiwi blokes have been good at that for years...If the door breaks fix it. Don't get somebody in to fix it. You fix it. You'll know how to do it. You've probably got a shed full of tools and you just go and find the right one and you just fix it. If you can't fix it most probably your mate next door will tell you how to fix it anyway. (M#2:2227)

Taken together, the preceding research and theorising enable us to understand that because of specific characteristics associated with the traditional male gender role, these men are likely to avoid, minimise, or deny situations in which they risk being vulnerable. Consequently, it is possible that these men have less lived experience of

personal or patient vulnerability. Also, under the prevailing cultural expectations for males, it is likely that it is difficult for these men to acknowledge their vulnerability and to openly discuss it with others because it represents a threat to masculinity or the sense of male 'self' (Cameron & Bernardes, 2000).

As discussed in Chapter 7, these men tend to present vulnerability as a patient position they live within the relationship, where they perceive they are in a weaker power position relative to the practitioner. Their data suggests then that these men perceive vulnerability to be the end product-state of specific relational dynamics, which is in line with the Cameron and Bernardes research that finds men tend to deal with their health care mechanistically, in terms of inputs, outputs, and effects. This is further borne out by the men's subsuming vulnerability as an aspect of Risk, a theme which presupposes risk assessment – possibly a more familiar activity as it is lived by these men (Easthope, 1998; Gergen, 1995), and perceived by them as a valued masculine trait according to the traditional Western gender role for males (see Bloor, 1995).

Knowledge and Voice

The next two shared facets of patient trust, Knowledge and Voice, are constructed as major themes for the women and as constituent aspects by the men of their theme, Autonomy. Because of the focus on the individual, the women locate the themes Knowledge and Voice in the 'She' domain, the men similarly locate Autonomy in their 'He' domain. According to feminist and gender literature because of the historical systems of "patriarchal domination" (Oakley, 1993) and oppression that our contemporary society has been built on, women have had restricted access to both

knowledge and voice in Western society generally and in health care relationships specifically, as discussed in the previous section. In this way the micropolitics of the patient-practitioner relationship reflect the macropolitics occurring in society.

Melissa remarks during the collective analysis of another woman's memory-text written around power and control issues that she experienced with her PHCP:

"Knowledge is power and power is control" (W#3:301). Melissa shares the view of academic theorists such as Foucault (1980) and Wilkinson and Kitzinger (1994), who have helped to deconstruct the discourses of power, control and authority that have characterised medical health care, and opened the way for alternative ways of knowing (e.g., lay knowledge of health and illness, and women's way of knowing) and relating with PHCPs.

It is clear from their interpretation and organisation of their data that knowledge and voice are at the forefront of the women's trust experiences. Their framing these trust facets as major themes reflects wider social changes. These changes are based on a recognition of the needs and rights of women for more knowledge, more say, and more power in a particular type of professional relationship in which they have long been expected to be passive, unquestioning objects of the agents of biomedicine.

Within the literature, these social changes are reflected in the growing interest in consumers' subjective accounts of their purchase experiences (e.g., Friend, 2000), and patients' narratives of lived health care as 'legitimate' types of knowledge. At a more personal level, the thematisation of knowledge and voice may well reflect a heightened awareness in these women that these two trust facets are particularly

important at this point in time in the lived renegotiation of women's place(s) in the health care relationship.

For the men, knowledge and voice are positioned within their experience of autonomy in relation to trust. Social history does not require men to struggle out of the same patriarchal patterns of oppression that have constrained women. But their data indicates that frequently they too struggle against a prescribed patient position of subjugation that they both anticipate and encounter in their relationships with PHCPs. The autonomy that these men are concerned with points then to a tension between how they have been socialised to be as males in society and how they are expected to relate within the health care relationship. Autonomy and mastery, "the hallmarks" of Western masculinity (Jordan, 1997b, p. 54) in general, are found in King's "man alone" model of the Kiwi male (ibid.) that values independence and self-reliance. This model for being male is endorsed by such ideologies as individualism and consumerism.

It is understandable then that autonomy can become a very important issue when these men find themselves in any health care context where they feel disadvantaged both by lack of knowledge and a dehumanising patient role that puts limits on their speaking. In such relational contexts whatever autonomy these men have developed over their lifetime could be threatened. Their data shows that for these men the trust aspects of knowledge and voice are secondary to an overall concern in their health care relationships with maintaining the autonomy, an autonomy that theorists (Gilligan, 1982, 1995; Peter & Morgan, 2001) hold is integral to the predominant contemporary male identity.

Responsiveness and Professional Confidence

Responsiveness and professional confidence are two more shared facets of these patients' trust in their PHCPs, occurring at the 'Cure'-related level in the PHCP as Other domain. Separate themes for the women, responsiveness and professional confidence appear in the men's work as aspects of the single theme Professionalism; responsiveness as a practice skill and professional confidence as a personal characteristic of the professional health care provider. These thematic positionings mirror the women's experiencing responsiveness and professional confidence at a distinctly personal level. Certainly, while ultimately they relate both facets to 'cure' per se, they live them as valued person-to-person dynamics. Personalised, timely responsiveness and fear-reducing professional confidence relate to how the practitioner as an individual interacts with the woman, as one human being interacting with another, albeit in the context of a professional health care relationship. An historical expectation of PHCP insensitivity toward them (see Hardey, 1998; Lupton, 1994) and their own past experience help explain the importance that the women place on responsiveness here.

That the women constructed a major theme of Professional Confidence also shows that this is another area where gender intersects with trust. Professional confidence works on different levels for these women. First, at an emotional level, this confidence reduces the women's fear and re-assures them. Perhaps, because it concerns the women's vulnerability then, PHCP confidence becomes a very personal, intersubjective part of their patient trust. Second, at a cognitive level, professional

confidence is perceived to be an indicator of PHCP clinical skills, which lie at the heart of the patient-practitioner relationship. The woman goes to the PHCP because she needs help with a health care issue she cannot deal with herself. Professional confidence indicates competence, and therefore, that the provider-customer relationship is going to be successful insofar as it looks likely that the woman's needs will be met. PHCP confidence also signals reliability and dependability, and so provides more support for the woman to trust that this PHCP will fulfill the promise implicit in the professional position: that she or he is competent to help.

The male participants take a more detached stance on the facets of responsiveness and professional confidence, including them as elements of an overall set of role expectations they have of the practitioner as a professional. So again, we see the men making sense of facets of trust in terms of the positions and roles they understand for the individuals involved in the relationship, a way of knowing that objectifies the humans involved and their relationship, and depends on clear boundaries and separateness. Gender theorist Jordon (1997) identifies this emphasis on 'differentness' as another basic tenet of males' gender socialisation (strengthened by individualism), one which carries the risk of culminating in "the creation of a pathologically isolated individual struggling to maintain the illusion of self-sufficiency and boundaries: the narcissistic solution of the ...Western man" (p. 145). The women's more subjective standpoint on PHCP responsiveness and professional confidence ties into the notions of relatedness and relationality, these days commonly presented as stereotypical feminine traits (e.g., relationship marketing theorists Doney, Cannon, & Mullen, 1998, and Palmer, 1995; sociologists Kaplan & Marks, 1995) and which clearly remain active ingredients in the genderisation of these women.

It must be noted that the women's and the men's positioning of responsiveness as a cure-related facet of the PHCP's relational behaviour steps beyond care-based nursing approaches (e.g., practitioners Benner, Tanner, and Chesla, 1996; Montgomery, 1993; Watson, 1988, 1989), which tend to develop responsiveness as a sensibility of caring. Montgomery, for instance, has us appreciate responsiveness as a natural "sensitivity to the human vulnerability inherent in health care" (1993, p. 58). While the women's work on responsiveness does acknowledge the practitioner's intersubjective sensitivity (e.g., "He [the GP] went with what Jane was feeling and said 'Okay. So you feel something's not right – then something's not right'" (Melissa, W#2:2707), the research shows that these patients construct PHCP responsiveness, finally, as an integral component of the PHCP cure capabilities that they collectively link to trust. The women's meaning-making would seem to find support from those nursing scholars (e.g., Peter & Morgan, 2001) who advocate a new model of nursing ethics that integrates both the cure and the care approaches, to overcome the shortcomings of a single focus on either cure or care alone. It also serves as a reminder that researchers must be aware that when we unpick the strands of any experience we need to keep an eye on the whole picture. Sometimes, an unravelled strand does not tell the same story in isolation that it does when it is woven into the fabric – it has changed in the unpicking.

Responsiveness has been named a service quality dimension in the marketing literature (see Zeithaml & Bitner, 1996) but its links to customer trust have not been explicated. There are similarities between the participants' constructions of Professional Confidence and the concept of assurance found in the same literature.

Assurance has been directly connected with the development of trust in customer-provider relationships (op cit.). This research links both the service provider's responsiveness and professional confidence to trust, theorising some critical interactional connections with gender.

Thoroughness

Thoroughness is another theme of the women's that is lived at a personal level but ultimately made sense of within the cure-related PHCP as Other domain. The men also locate Thoroughness here in the heuristic but configure it as an aspect of their theme Clinical Skills. As Chapter 6 detailed, the importance of Thoroughness for these women is based on its value as an indicator both of PHCP competence and of the PHCP's interest in relating to the individual woman as a person. Research finds that women's accounts of their own symptoms are often ignored (Broom, 1998) and trivialised by doctors (Graham & Oakley, 1986), and the female participants themselves speak passionately about the risk of being labeled deviant or mentally deranged if they do not conform to the prescribed patient role for females, which is also explored in the nursing literature (e.g., Pilgrim & Rogers, 1993). For female participants who experience and indeed have learned to anticipate such sexist responses in their health care contexts, this research suggests that thoroughness signals a practitioner who, rather than ignore or dismiss them, is likely both to treat them competently and to provide individualised health care relative to each woman's personal circumstances.

Although the men also identify thoroughness as a common element of their trust experiences they make sense of it as an aspect of the practitioner's clinical skills, and thus part of the provider's role. This fits in with insights derived from Gilligan's (1982, 1995) work describing the ethic of justice which is characterised by the following 'masculine' moral considerations: abstract rules and principles, fairness and reciprocity, and duties and obligations for self and society. Underlying this masculine ethic is a conception of each person as autonomous and separate, with the focus on self rather than relationships (Peter & Morgan, 2001).

Risk

The literature on gender holds that gender pertains in large part to the roles which men and women occupy in the family and work. Expectations about what men and women appropriately should and should not do enter everyday life through gender, and "profoundly affect" (Waitzkin, 1991, p. 39) our interactions at all levels, including our construction of health and well-being and the patterns to our health care consumption (Cameron & Bernardes, 1998). Theorists and social commentators have recognised for some time now the key role that risk plays in health inequalities between men and women (e.g., Arndt, 1996; Goodyear-Smith & Birks, 2003). Because men are more likely to be in dangerous and physically demanding occupations they are at greater risk than women of dying from occupational accidents. Alongside potential workplace risks, men also engage more than women in general behaviour that puts their health at risk, such as drinking to excess, smoking, unsafe sex, dangerous driving, and dangerous sports (Goodyear-Smith & Birks, 2003; North Health, 1996; Doyal, 2001). The growing literature on masculinity links such risk-taking behaviours and their

effect on male mortality and morbidity rates directly to gender. For instance: “Many men feel compelled to engage in risky behaviour in order to ‘prove’ their masculinity” (Doyal, 2001, p. 1062). Risk thus emerges from such work as a key construct in traditional notions of male gender identity and masculinity.

Coupled with this emphasis within male genderisation on risk, the traditional male ethos ‘teaches’ men from an early age to be self-sufficient, self-reliant, and stoic; conversely, being vulnerable or asking for help is seen as not acceptable (Tudiver & Talbot, 1999). The literature shows that risk is an important construct within male genderisation and can play a large part in the everyday lives of some men generally. It is reasonable to expect therefore that these men would give more weight to risk than vulnerability in their scheme of meaning-making for their trust and health care experiences. This suggests that further exploration of gender and the perception of risk is warranted.

Professionalism

The traditional social role for the male as the provider or primary breadwinner is commonly used by theorists to help explain men's general denial of health risks and reluctance to seek health care (e.g., Goodyear-Smith & Birks, 2003; North Health, 1996). In Arndt's words: The man's “masculine health which threatens his job can undermine the essence of his manhood...So in part, men deny health risks because they can't afford the consequences of discovering problems which could interfere with their good provider role” (1996, p. 88).

Their theme of Professionalism encapsulates the expectations held by these men that the PHCPs they consult will “do the job” (R., M#4:290). At the core of their role description for the PHCP is the expectation that the practitioner will efficiently and effectively deal to the health problem so that they can get on with life and get back to doing their job in a society which values achievement and employment (Doney, Cannon, & Mullen, 1998; North Health, 1996). From this perspective then, a speedy health care ‘fix’ by the health care professional averts any perceived threat to their gendered identities and roles, and thence maintains social order. Inherent in the men’s Professionalism, comprising certain personal traits and practice skills relating to effecting the ‘fix’, is the implication of increased chances of a speedy cure and return to daily life, and decreased chances of major disruption to the structure of their selves and social relations.

Parson’s (1951) theoretical account of health, illness, and medicine offers some useful insights to the men’s theme of Professionalism. Taking a structural-functionalist approach, this theory examines the doctor-patient relationship as a micro-social setting which reflects macro-social structures such as norms and the socialisation process, what he terms the “patterned roles” (p. 433) of the social system providing the context for the medical encounter. Parson’s conceptualisation of the ‘sick role’ for patient behaviour, and the ‘physician role’ for appropriate doctor conduct is now well known. He holds that because medicine is a service and there is no exchange of product as such, trust must be based on abstract codes of conduct that are embedded in these roles. The patient must adopt and display certain ‘sick’ behaviours, specifically those that show she/he regards illness as undesirable and that she/he will co-operate willingly with the doctor to get better. Similarly, the doctor must behave

towards patients in certain ways, in order to convey to them that the good of the patient and society at large are paramount over financial gain. This altruistic, collective-good position endorses the shared goal of doctor and patient, indicates trustworthiness, and thereby secure the patient's co-operation and compliance (Bury, 1997; Germov, 1998; Lupton, 1994; Parsons, 1951, 1975; Samson, 1999).

There is a strong theoretical link here to the men's work in this research.

Professionalism, as it is lived by the male participants, is a key component of the practitioner 'role' that they have constructed for PHCPs. Their Professionalism amounts to the code of conduct for PHCPs which, as Parsons theorises, is critical to the patient establishing trust in clinical encounters. Thus we can see how the trust theme of Professionalism might be formed partly around learned codes of conduct or roles, and the shared goal of these men and their practitioners of returning the man to work and the social system as soon as possible. The macro-climate would seem to foster the men's experience of roles and professionalism in their patient-practitioner relationships. Outside the clinic these men live in a society that continues to promote rationality, the supremacy of science, separateness and individualism for males. Such values are congruent with the men's construction of Professionalism and its focus on the health care task, efficiency, and a well-defined, commonly understood role prescription for the service provider. While these are not the only values society teaches are appropriate for men today, they nevertheless constitute the dominant masculine model (Lee & Owens, 2002).

The women organise PHCP professionalism into two aspects. The first of these aspects highlights the 'cure' nature of professionalism and is located in the cure-

related theme Professional Confidence. The second of the aspects reflects the 'care' dimension of professionalism, and is found in the care-related Empathy theme. Under Personal Confidence the women organise the professionalism that they experience as part of the sense of assurance perceived in the PHCP. This theme, which has been discussed earlier in this section, suggests that the women understand professional self-confidence in their practitioner as an indicator of clinical competence. In this regard their experience of professionalism is similar to the men's.

One of the interesting differences in how the women and the men construct professionalism is found in the standpoints the women and men take on this particular trust facet. From the more subjective perspective taken by the women professionalism is tied into the practitioner's way of relating, from the more detached standpoint taken by the male participants, professionalism can be understood as part of a way of behaving. Both of these standpoints and the differences inherent in them, are linked to traditional gender stereotypes by theorists and the participants, as discussed in preceding paragraphs. The men's data suggests that the gendered differences in the lived experience and construction of professionalism could be profitably examined by future researchers applying role theory.

The participants' experiences of professionalism across both genders also link directly to the very nature of the health care relationship: that of a provider of a professional service and the customer of that service who expects certain behaviours, responses, and attitudes of the provider during the delivery of that service. In the context of a professional service encounter, marketing theory recognises that customers use the perceived professionalism of the provider as one of the quality attributes upon which

they evaluate the overall quality of their service experience (see Gabbott and Hogg, 1998, for an overview of the nature and distinguishing features of professional services, and the characteristics of the professional services consumer).

Empathy is the second of the women's major themes of trust that includes PHCP professionalism as an aspect. Professionalism appears here in the form of a distinctive type of caring – a caring that the women expect the professional to manage with restraint to match the needs of the individual woman at the time. Thus, we see the women connect trust to a PHCP caring that is marked by emotional detachment on the one hand, and at other times to a PHCP caring they call compassion with a much larger degree of perceived emotional involvement. The women relate professionalism in this theme to the practitioner's ability to manage the emotional component of caring according to the situation and the patient's personal needs. This construction of professionalism is understandable in the light of the women's experiences of vulnerability and their wariness of exploitation by the PHCP within the patient-practitioner relationship (refer to 'Vulnerability' section, Chapter 6, and 'Empathy' in the preceding section of this chapter). And, depending as it does on a sensitive responsiveness and relational flexibility in the practitioner, this construction of professionalism as part of Empathy is yet another of the women's common sense-makings that reflects the relationality they live in their trust experiences overall. This provides considerable depth to the general construction of empathy within the services marketing literature as "treating customers as individuals" (Zeithaml & Bitner, 1996, p. 122).

‘Reading’ Skills

Although it is configured differently by the women and the men, ‘reading’ skills is positioned by both groups as a care-related facet within the PHCP-as-Other domain of their experiences. This shared positioning warrants two comments. First, it highlights another specific area of PHCP care that is critical to patient trust for both genders, providing more support for theorists and practitioners from various disciplines who urge that we recognise and integrate the subjective dimensions of human experience in our academic theorising. Second, although it is the patient who is the person being ‘read’, the participants clearly place the focus here on the practitioner, which in turn highlights the place and responsibilities of the PHCP with regard to the interpersonal skills s/he needs for this particular relational dynamic to develop. The male participants frame these skills as the major trust theme ‘Reading’ Skills, and the women consider it a subsidiary aspect of Personal Connection. Considering the interaction of gender on the participants’ experiences goes part way to explaining the difference in their configurations.

The core of the men’s construction of ‘Reading’ Skills is the practitioners’ ability to truly appreciate the whole illness experience of the male patient in front of them. Relative to traditional masculinity and the traditional biomedical model for a male patient, this intersubjective holistic dimension to their health care experience is likely to cause problems for the men. The traditional model of masculinity promotes self-sufficiency and teaches men not to think, feel, or talk about emotional or physical discomfort (Arndt, 1996). The traditional patient role compounds these with more expectations that the individual respect and obey the medical expert, keep quiet and

be cooperative (see Chapter 2: Putting Health Care into Context). Neither of the traditional models allows for the male patient's subjective experience of illness. Thus, for some men, it is probable that there will be serious tensions between what they have been taught for so long by society is the right way to experience health care and how they find they live it as individual human beings. The work of these men clearly endorses the place of 'care' in their experiences of primary health care. However, their work also suggests that, as males, they do experience various difficulties in the health care context, both articulating their care needs and having these met by the practitioner.

'Reading' skills in the practitioner could be perceived by these men as another indication that the PHCP is likely to provide 'care' in relational situations where they themselves might be experiencing socialised difficulties with the subjective dimension of their ill-health. These 'reading' skills seem to signal a practitioner who is willing and able to relate to the male patient as a person, and is experienced enough in interpersonal relations to discern and elicit personal details about the patient when he himself is not comfortable sharing such information. Moreover, because health care consultations tend to operate under tight time constraints, and/or because some men continue to avoid seeking help for as long as possible (North Health, 1996), the patient-practitioner relationship often must develop quickly to deal with high involvement health care situations. Good 'reading' skills hold a promise of efficiency and it is possible that they indicate to these men that the practitioner is experienced in managing relationships under conditions of urgency.

As a theme then, 'Reading' Skills implies a receptiveness or openness by the practitioner to the personal details and implications of the illness for the individual male. But more than that, it also contains a perception by these men that the practitioner be pro-active in gathering information about the patient's experience. Implicit in this perception is another subtle reference by the men to the role of the practitioner. This implication that the men expect the practitioner to be a good reader as part of the job helps explain the detachment that underlies the men's exploration of this theme, despite the fact that it concerns the subjective nature of the trust experience for them as patients. The men construct the theme around their common-sense of PHCP sensitivity and perceptiveness, listening, and comprehension skills. In combination, these skills are perceived by the men to be vital for the intersubjectivity that they identify as a component of deeper relational trust in the patient-practitioner relationship.

The women configure similar experiences and understandings in their Personal Connection theme (discussed fully in the section Common Trust Themes earlier in this chapter). In particular, the women's aspects of 'listening skills' and 'PHCP intuition' reflect trust facets that they share with the male participants. The women though tend to regard these aspects more as a means to an end (that being the Personal Connection between practitioner and patient), rather than as an end in themselves (e.g., the men's construction of PHCP 'reading' skills as a discrete set of relational skills). In other words, the women appear to make sense of these aspects more as clues to the quality of the relationship-in-progress they are living, rather than as indicators of potential quality of the job the practitioner is going to do. Looking to the interaction with gender, it is possible that the emphasis of traditional socialisation for

women on relationships (e.g., Gilligan, 1982; Peter & Morgan, 2001) and the dominant discourse for female patients' (e.g., not being listened to by the PHCP, and related to as a dehumanised body-object) affect their configuration of these particular trust aspects. These trust themes that share some commonality between the men and the women, reveal important gendered nuances to the trust phenomenon which have not been noted previously by trust theorists. While concepts such as Vulnerability and Responsiveness have been theoretically identified with trust the literature seems to assume that customers' experiences of these trust facets cut across gender.

8.4 Gendered Trust Themes

This thematic analysis develops four themes in the women's trust experiences that do not constitute a major part of patient trust for the male participants, and four main trust themes in the men's data that are not reflected in the women's work. These eight themes are displayed overleaf in Table 5: Gendered Themes in the Participants' Experiences of Trust in PHCPs.

The following section discusses these gendered themes individually and again looks to historical, cultural, and social patterns of gender in an effort to generate better knowledge and ways of understanding patient trust in relation to gender, as these participants have lived it. The first four themes discussed are the gendered trust themes constructed by the women

Table 5: Gendered Themes in the Participants’ Experiences of Trust in PHCPs

Theme	Aspects
<u>Women</u>	
Affirmation (‘She’)	Sense of Self Personal acknowledgement Validation Individualised care
Acceptance (‘Other’)	Unconditionality Impartiality
Safety (‘They’)	Security
Empowerment (‘They’)	Control Self management Power
<u>Men</u>	
Evidence (‘He’)	Proof of PHCP trustworthiness Proof of progress Proof of treatment Physical evidence Money
Autonomy (‘He’)	Self determination Knowledge Voice Evaluation by patient Self-control Patient’s best interests
Friendliness (‘Other’)	Warmth Good Humour
Alliance (‘They’)	Agency Equality

Women's Theme: Affirmation

As their positioning of this theme indicates, the women understand this facet of patient trust as it relates to them each as an individual; more specifically, as it relates to the woman's deep sense of self, often at the level of Soul, through relational experiences of acknowledgement and validation. The women also account for their individualised health care from the PHCP in this particular theme: it is a practical demonstration in the health care context of her uniqueness and thus honours her sense of Self.

Clues to understanding the interaction of gender with these Affirmation experiences lie in the women's discussion about their socialisation as women and as female patients. They turn repeatedly to the topic of how they were "brought up" (Emma. W#3:508) to put the needs of others before their own. For instance, in the following excerpt the participants refer to this particular mandate to subjugate their own needs to others', which they experienced in their socialisation to 'be' mothers, female patients, and women:

Melissa: We don't think of ourselves as important once we become parents.

Amy: And that's what you were saying before Jane, about 'I don't want to yell and scream and cause a ruckus'. We are still thinking about other people and other people's perceptions of us during this process [childbirth], rather than thinking about ourselves and thinking 'What? I have a right to...'

Jane: 'I'm in pain here!'

Amy: 'I have a right to this!'

Jane: 'Excuse me! It's me that hurts!'

Amy: I would say that's probably a woman thing.

Melissa: Yeah. (W#1:172)

Added to these were extra lessons in the woman's subjugation of needs, learned from parents, partners, and from past experience with practitioners:

Emma: ...growing up I was always taught 'You sit there and you be quiet and you don't say anything until an adult says something to you' (W1:715).

Melissa: So once again you [Jane] were thinking about everything but yourself? You would have quite happily gone home and stewed with the appendicitis rather than upset him and his work routine.

Jane: I could see that he was thinking about the kids as well, and 'We've got this friend sitting at home with them' and 'What time were we going to get home?' and 'I've got to be at work at 7.30 in the morning' and whatever, whatever, whatever...I felt like he just didn't give a shit, quite frankly, apart from the fact that I was upsetting his orderly life. (W#3:2234, 2447.)

Melissa: We've all been taught that your doctor's time is more important than yours...(W#1:706).

Louise: I feel awkward about bothering him [her GP] with stuff that maybe doesn't turn out to be all that important...

Melissa: That's part of that 'They're-more-important-than-us' syndrome.

Louise: Yes it is...As in, 'Don't bother them'. (W#2:2304).

Norms for female subjugation, such as these discussed by the participants, are intertwined through the layers of context in which their everyday lives take shape. Layered one on top of the other, and reinforced simultaneously by patriarchy and paternalism, and in the health care context by the biomedical discourse (Lupton, 1994; Scambler, 1998), such normative guidelines for female behaviour can work to erode a woman's innate feelings of worth and threaten her sense of who she is.

Affirmation as a topic has received little attention in the marketing journals.

Relationship marketing theorists, Sheaves and Barnes (1996), are one exception. They name affirmation as a significant benefit of service relationships, pointing out that customers can use a service relationship to gauge “the reliability and validity of his or her actions and beliefs” and thereby “reaffirm his or her own value as an individual” (p. 221). This can be linked into the research in marketing that deals with consumer self-identity and the behaviour which protects and enhances that identity (e.g., Friend, 1997; Friend & Thompson, 2003; Oumli & Erdem, 1997). While it might not name ‘affirmation’ specifically, nevertheless this literature often seems to imply it: “...in regard to social concepts, [these] experiences illustrate how not belonging to the encounter, in ways that threaten their sense of identity, lead to their dissatisfying shopping encounters” (Friend & Thompson, 2003, p. 36).

In the health care literature we find considerably more attention given to affirmation and the constituent aspects of validation and acknowledgement that these participants integrate in the theme (e.g., du Pre, 2001; Glass & Walter, 2000; Montgomery, 1993). Moreover, this literature frequently makes explicit the connection between affirmation and a patient's personal spirituality, which is a feature of the theme for the participants: “Spirituality is the source of one's values and meaning, a way of understanding the world, an awareness of my ‘inner-self’, and a means of integrating the various aspects of myself into a whole” (Strack, Fottler, Wheatley, Sodomka, et al., 2002, p. 6).

Most of these features of the women's Affirmation theme are problematic to a large degree (for both genders) under patriarchy, paternalism, and positivism in general,

and consequently suppressed within relational contexts modeled and supported by these ideologies (e.g., bio-medical health care). Added to the general difficulties with recognising and valuing the dignity of the individual human being within these discourses, historically women also have been 'denied' their needs and realities simply because of their gender. Commentators agree that these ideologies prevail and continue to dominate the shape of the contemporary New Zealand health care context (e.g., Dew & Kirkman, 2002; McLennan, Ryan, & Spoonley, 2000), but their privilege has been countered by the growth of ideologies like feminism and individualism.

So, the denial and devalidation of womens's realities by patriarchy, paternalism, and biomedicine have in a sense sharpened the need in women for affirmation. But, the counter-discourses of feminism, consumerism, and individualism, and personal encounters with PHCPs who practise patient-centred health care, have helped women become aware that they have the right not only to have individual needs (including affirmation), but the right to have these needs met within relationships (Hardey, 1998; Oakley, 1993). This increased awareness is lived in the health care context by many women as a growing sensitivity to how their needs are acknowledged, respected, and met by practitioners. These complex social conditions help explain how and why Affirmation exists as a major gendered theme for the female participants in their patient trust experiences today.

Women's Theme: Acceptance

Acceptance, constructed as a major theme by the women's group in this research, is found within the 'Other' domain of their trust experiences, relating specifically to the practitioner's relational care responses. The theme's focus reflects the women's concerns with being believed and taken seriously, unconditionally and without judgement, by the practitioner. The most important of the PHCP care responses for these women, Acceptance amounts to the practitioner's response to their 'Self' needs, for affirmation and voice in particular. This relational dynamic between the theme of Acceptance and the themes of Affirmation and Voice suggests that the same historical and cultural conditions that inform our understanding of the gendered natures of Affirmation and Voice, also will be useful in understanding why Acceptance is a gendered theme.

The same male-dominated social conditioning developed out of patriarchy, paternalism, and positivism, which has devalued women and dumbbed down the female voice, underlies the traditional medical model of health care (Armstrong, 2000; Hardey, 1998; Lupton, 1994) and continues to be a part of the women's experiences in this context today. The women continue to encounter non-acceptance because of their gender both in their daily lives and in their health care relationships. It is most commonly experienced as disbelief, dismissal, or denial of her Self, happens across a range of social contexts at different ages, and was active in their socialisation as female children and significant in their childhood experiences of trust:

I couldn't tell Mum and Dad because they would look at me differently. And also, yeah, the fear of not being believed. And as it turned out, years later when I told Mum she was in total

disbelief. She just couldn't accept what I was telling her (Emma, talking about being sexually abused by her grandfather. W#5:406).

That was the socialisation thing...nobody cares enough about us to listen (Melissa. W#5:793).

So not only is there the fear for me in this particular situation that he [the GP] is just going to echo the comments I have heard for the previous couple of years anyway – which seems to be a standard male response to a female trying to articulate emotions and feelings – but there's stuff that goes back to our parents...At some point we've become afraid that they are not going to believe us...that if they are given a choice of believing us or believing somebody else, they will automatically believe the adult. Or believe the other person (Louise. W#5:901).

The pervasiveness of non-acceptance throughout the layers of the women's lives is supported by various gendered social practices that are experienced as sexist, and is also perpetuated by the women themselves when they respond according to the normative guidelines for a woman prescribed by such practices. These non-acceptance experiences effectively 'teach' them to expect it on the one hand:

Melissa: ...you automatically think that people are going to be critical...

Emma: Judgemental.

Melissa:...because for so long you have been told that everything's your fault and [asked] why you are being so stupid.

Emma: And it's amazing how much of that you can tolerate.

Melissa: And before you realise it you believe it (W#5:152).

Conversely, their non-acceptance experiences also 'teach' the women to be grateful and relieved, to delight in acceptance when they feel they are related to as valuable persons in their own right. (The notion of 'delighting the customer', important in the

satisfaction and services marketing literatures, underscores the marketing implications of Acceptance in the marketing of health care services to women.)

In the women's psychology literature theorists like Jordan, Kaplan, Miller, Striver, and Surrey (1991) and Jordan (1997b) theorise acceptance of one person by another as a pathway to interpersonal connection, a relational state valued by both the women and the men in this research and identified as a common theme to the trust experiences of both genders (see earlier Personal Connection section). These theorists agree that the need for connection is basic to all humans, but hold that it is particularly important to women. Moreover, these scholars contend that women's experiences and needs have been dismissed under Western society's systematic handling of difference through relational processes built on hierarchy and dismissal. Echoes of the participants' work on acceptance are visible in the following passage by some of these theorists:

Unfortunately, our experience has typically been that different means less than, or not good enough. Being alike has come to mean being normal and different as being abnormal. Our culture tends to polarize and dichotomize; to be seen as different triggers unconscious attitudes and fears that are deeply engrained in our culture and in ourselves (Coll, Cook-Nobles, & Surrey, 1993, p. 188).

Acceptance, which according to this epistemology facilitates connection, marks a relationality that accommodates diversity. The women's data richly testifies to this; they indicate that acceptance of the woman patient and her realities by the practitioner signals an openness to meaningful understanding and trust within the relationship.

Much of the women's development of Affirmation refers to the pressure that they feel to cope – as wives, mothers, and female patients. A complex mandate, coping is

linked to the value society places on good health (see Hardey, 1998) and being a fully-functioning member of that society: “You’re not supposed to have problems and you just get on with it and stop complaining” (Emma. W#4:1604). The participants speak about doing their illnesses “tidily” (Louise. W#4:1722) in order to maintain the social status quo by meeting their role expectations: “When I’m sick I am trying very hard not to inconvenience the children, still trying to keep my mummy role” (Amy. W#3:2583) and

When I had post-natal depression, and I didn't know that I had it, and it didn't get diagnosed till Rachel was about 15 months old. I kept doing whatever I could think of to try and snap out of it, you know. And I remember saying to Den one day, 'Look. Aren't I being good – the housework's done, tea's cooked, everything's ready for you when you get home from work, and I'm not nagging you about what time you walk in the door' (Jane. W#4:1616).

The women agree that the social imperative is gendered insofar as “we have to cope but because of the way society works, when a man does get sick he can go to bed and he can forget it, whereas the women have to be sick around their other obligations” (Melissa. W#3:2611). The mandate for a woman to ‘cope’ with her illness without upsetting those around her is in line with the normative guidelines for a ‘good’ woman set down by patriarchy and paternalism. The mandate also is consistent with the self-sufficiency advocated by individualism and the independence urged by the early feminist movement. Women’s illnesses have the potential to rupture the social fabric of daily life by threatening their ability to nurture and the socialised expectation that they will put the welfare of others before their own. Certainly, the social imperative to cope safeguards the integrity of her social milieu to a large extent, but often it does so at a cost to the individual woman (Hardey, 1998; Williams, 1993).

At its worst, the pressure to cope works to silence these women; they commonly take great efforts to conceal their health problems, and play down how ill they feel. This pressure is implicated in the sense they often experience in ill-health of being isolated, which Melissa describes as “a feeling of loneliness and feeling of lack” (W#3:3161) and the growing self-doubt that can accompany such a perceived inability to cope. It figures too in the women's need for practitioners not to judge them as failures; for instance, as a “mad” woman (Emma. W#4:1571), or a “bad” mother (Melissa. W#5:1436).

In the interest of successful, profitable business practice, marketing is proactive in eliciting from customers their experiences of consumption, and urges practitioners to have their customers identify their needs and wants. The emphasis and credence given to the consumer perspective by the marketing discipline implies a very broad acceptance of consumer realities. However, there is little in the marketing literature on the dynamics and impact of the service provider's personal ‘acceptance’ of the individual customer at the level of their person-to-person relationship. That the female participants construct a major theme of Acceptance indicates that for these women it is an important facet of trust in patient-practitioner relationships and therefore worthy of deeper examination.

Women's Theme: Safety

This gendered theme occurs in the ‘They’ domain of the women's trust experiences, and therefore is concerned mainly with the relationship, the “space in between” the patient and PHCP. Zohar, physicist and philosopher, calls this relational space “the

both/and” of a relationship, where the ‘I’ who is uniquely me is “something larger than myself” (1991, p. 113). Following this line of thinking, developed most fully in the complexity literature, the relationship between two individuals is a compound of ‘I’ and ‘Other’ and a new thing in itself with its own qualities. This can be seen to be a natural theoretical progression from the work done on ‘connection’, regarded by some theorists (e.g., Jordan., 1997a, b) as a female way of doing relationship. The trust experiences and research work of the female participants certainly reflects this understanding in the themes they construct in the ‘They’ domain: Reciprocity, Safety, and Empowerment.

Their trust theme Safety comes together around the women's sense of the patient-practitioner relationship being a relational space in which they feel secure and protected. It exists relative to the risks these women perceive in the context. It is experienced by the different women across a range of situations, and thus has different focuses for individual females; including PHCP competence, PHCP empathy, PHCP dependability, her lifeworld, and her Self integrity (physical and emotional). Possible explanations for Safety's gendered nature can be theorised by moving between the micro-context and the socio-cultural context of the women's lives.

The number and nature of the incidents of health care malpractice, sexual harassment, or negligence involving female patients that have come to public attention over the past few years is likely to affect the women's construction of Safety as a gendered theme. These cases provide real-life examples from the New Zealand context (for details see Chapter 2) of what feminist health care theorists identify as a particular set

of gender inequalities (apart from the standard mortality and morbidity differences between females and males) in patient-practitioner encounters. The New Zealand cases confirm the international research that has found that the interaction of gender and illness can create serious problems for women in their interaction with PHCPs, due in particular to the gendered nature of the medical profession and the nature of biomedical knowledge.

Such research has found illnesses being investigated less thoroughly and treated less aggressively in women than they are in men, women not offered potentially beneficial therapies, and restrictions on the information, choices, and health care services being given to women (detailed in Broom, 1998; and Hardey, 1998). Other research finds gender-related problems in the patient-practitioner relationship, referred to as “sexism in medicine” (Broom, 1998, p. 48). This work finds that at times women's health concerns are not taken seriously in consultation, male doctors do not interact appropriately with female patients, and doctors are inclined to label women's health problems ‘psychosomatic’ rather than real (Annandale, 1998; Broom, 1998; Bury, 1997; Coburn & Willis, 2000; Dew & Kirkman, 2002; Hardey, 1998; Lupton, 1994; Oakley, 1993). Summarised broadly, this research concludes that such gender differences played out in the context of primary health care relationships reproduce the dominant assumptions held by society about social relations between genders.

In the light of this research therefore, we can understand that the ‘Safety’ theme is a response by these women to what is considered to be a universal set of difficulties connected to issues of ‘male dominance’, and the traditional stereotype of women and their role in society and relationship. Once again, it is likely that the very prevalence

of these conditions in the lives of the female participants sharpens their appreciation of relationships when they do experience safety as part of their trust. Certain 'newer' ideologies (e.g., feminism, individualism) at the same reinforce women's rights to be respected and treated as a worthy, unique individual.

At the national level of the participants' daily lives, publicity about health care scandals involving practitioners (predominantly male) and female patients, and the subsequent rise in New Zealand of women's self-help health groups and pressure groups serve to raise women's consciousness as female consumers of health care. Gendered safety issues around sexuality are recognised at the level of health care practice by those PHCPs who will provide female nurses as chaperones for female patients during breast and vaginal/cervical examinations, consultations with young female patients, and discussions of sensitive topics (e.g., termination of pregnancy). At the individual level, the women's own experiential knowledge of 'safe' health care teaches them relational alternatives to 'unsafe' situations in which elements of their physical, psychological, and/or spiritual well-being might be at risk in a relationship modeled on the traditional stereotypes for the genders.

A distinguishing characteristic of Safety for these women concerns the feeling of 'protection' that they experience in patient trust. Commonly regarded by women in a pejorative sense, due to feminism's construction of it as a patronising act of male privilege, 'protection' in the context of this research goes some way toward expressing the importance of a responsive PHCP who is trusted as an advocate for the woman and protects her rights when she finds herself unable to do so alone. In this way, 'protection' indicates certain relational dynamics in which the female patient

knows it is safe to depend on the practitioner to manage her health care in her best interests. There are obvious links between the women's theme of Safety and Andaleeb's (1992) trust facet, psychological safety. The women's construction of this facet into a major gendered theme however, shows that in this service context safety has more significance than previously recognised.

Women's Theme: Empowerment

This gendered trust theme is another that the women experience in the Gestalt of the relationship itself and therefore position in the 'They' domain of the research heuristic. It concerns, then, the experiences of 'power' lived by the female participants in the context of their relationships with PHCPs.

These women made sense of 'power' and 'empowerment' in several slightly different ways. One sense follows the understanding popular in everyday life which seems to focus on the site or holder of power, and conceptualise power relations as a struggle between social institutions or individual persons to wrest and retain power of one over another. This is the conceptualisation of power that is favoured and popularised by the ideologies of feminism and individualism (Gergen, 1995; Lupton, 1994). It is also the conceptualisation that underlies most of the discussions of power relations within the patient-practitioner relationship, starting from the recognition of the power and privilege modern society vests in the traditional scientific medical practitioner by virtue of the role itself (Sokolowska, 1986). Analyses of the patient-practitioner relationship based on this conceptualisation of power tend therefore to conceive of the doctor as a socially-sanctioned, powerful expert who exercises control over patients'

bodies, and to concentrate on the relationship as the site of a battle for domination by one and subjection of the other. At times in their experience of trust, individual women in this research relate to PHCPs from this stance on power and empowerment; they perceive that they are having to assert their own agency and wrestle control of particular aspects of their health care back from practitioners who were exercising it as of right. At these times then, the 'empowerment' experienced by the women conveys the sense of personal power reclaimed and re-asserted.

One of the best examples in the participants' work of issues of power and control lived from this perspective is provided by Melissa in her account of being "put in four-point leather restraints" to be forcibly subdued during childbirth, and subsequently, as part of her re-empowerment, divorcing the husband who had been present and helped in this perceived act of male control (W#3:220). In those situations where a woman did conceive power and empowerment in such terms, it is common to find that she and/or the practitioner are relating to the other from a discourse that either values hierarchy in social relations, or encourages agency as the way of being in relation to another.

This perception of how relational power is played out between the provider and the consumer prevails in the marketing literature, evidenced in the work that explores issues of power asymmetry and dependence (e.g., Andaleeb, 1996; Ganesan, 1994; Heide & John, 1988; Morgan & Hunt, 1994). It is implicated also in the research in the services marketing literature that examines gender preferences and effects between customers and providers (e.g., Palmer & Bejou, 1995).

Having made these observations and comments on power conceived of as a property of an agent's position, I turn now to the more common sense of 'power' and 'empowerment' upon which the women constructed this trust theme, before exploring the links between it and gender. Rather than a 'reclaiming' of power within the relationship, the sense underlying the theme is more one of a 'restoring' of the individual woman's personal power. In the sense it has not actually been taken away from her, Empowerment is experienced then as a remembering and revisioning of her capability to manage her health care.

This Empowerment occurs in the health care relationship when, rather than control and domination, she experiences connection; such a relational environment supports her exercising her power towards the achievement of certain health care goals (as opposed to exercising power over another). This view of empowerment then is concerned not with any sort of struggle to own the greater share of power-as-commodity in a relationship, but rather with the women realising their own innate power. This sense of Empowerment thus moves away from the theoretical work which rests on the assumption that patients are willing and able to act within their health care encounters as aware, autonomous, and rational individuals who can discern a power imbalance and address it by adjusting their relational responses accordingly (Lupton, 1996).

Rather, the sense articulated by these women aligns their theme with work that goes beyond the dominance model and instead theorises power as a relational vehicle for action located within the dynamics between the individual persons or groups (e.g., Gergen, 1995). There are theoretical parallels also with the body of research in the

nursing literature developed (largely on Heidegger's philosophy of Being) to explain ways of human 'being' and 'becoming' in relationship (e.g., Parse, 1995; Walsh, 1997). Such work recognises the rhythmicity and fluidity in relationship and the potential offered by relationship for moving beyond the limits of the self. Here we find theory that is beginning to account for the easy movement of power between the patient and the practitioner detailed by the women, as one and the other takes responsibility from within the relationship for certain "well-being-generating actions" (Riikonen, 1999, p. 143) focussed on the woman's health. In this theoretical scheme both patient and practitioner are expert (as expressed so clearly by the male participants in this research) and power per se is one element of the relationship's synergy. Power, then, is co-constructed within relationship and the women's Empowerment a realisation of the possibilities this affords her.

If connection and relatedness are feminine ways of being (Jordan, 1997a, b) that are reinforced in female gender identity by socialisation, then Empowerment can be understood to be a way of making sense of the power dynamics of the patient-practitioner relationship that reflects these. From this standpoint then, the women's trust theme of Empowerment can be considered to be gendered insofar as it is constructed in the context of health care around 'feminine' notions of sharing, cooperation, and relational flux. The male-dominated ideologies and discourses upon which Western health care is based, concentrating on individual autonomy and mastery, entitlement and self-control, do not admit these relational patterns.

Certainly, the traditional biomedical patient role can be said to encourage sharing and cooperation, but the women's lived experience of cooperation within Empowerment

goes much deeper than the unquestioning delivery of personal information and body, and the compliance expected. The theme of Empowerment highlights a deep relational quality to trust experienced by these women, and challenges theorists to move beyond the consideration of humans as social entities engaged in various exchange processes within relationship, towards understanding the place of the “conjoint reality” (McNamee & Gergen, 1999, p. 13) itself in sustaining social phenomena such as trust.

* * *

The following section of this discussion chapter focuses on those trust themes constructed by the men that emerge from the data analysis as gendered trust themes. These are the themes then that constitute a major part of patient trust for the male participants, and are not present at this level in the women's experiences.

Men's Theme: Evidence

Tied most clearly to their Risk theme (described fully in Chapter 7, and emerging from the data analysis at the 'He' level of the relational heuristic), Evidence also is located in the 'He' domain of the patient's experience, which focuses this theme squarely on the patient and underlines the importance of evidence at the level of the individual.

Many of the patient trust experiences of these men are charged with suspicion. Usually this suspicion is focussed on the PHCP, but on occasion is also directed at

family members. Their work reveals an undercurrent of suspicion that runs, at times very strongly, through the men's experiences, and which is also associated with profound feelings of isolation and anxiety for some of them.

There are three main areas in which this suspicion is implicated:

1. the men's use of physical evidence as indicators of PHCP trustworthiness. For example their attention to signage, parking facilities, location, décor.
2. their deliberate 'testing' of the practitioner throughout the relationship. For example, asking the PHCP to declare his/her position on a controversial health issue.
3. their purposeful monitoring and evaluation of aspects of the PHCP behaviour. For example, considered reflection and appraisal of such things as the practitioner's competence, treatment decisions, or motivations.

These men believe that one person's trust must be "earned" by the other (R., M#5:2561). It is this principle that guides the men's construction of trust as a transaction between the patient and the PHCP, conducted by the patient according to evidence of the practitioner's perceived trustworthiness or untrustworthiness. On this basis these men frequently start their relationships with PHCPs from a position of either suspicion or neutrality. The men use the analogies of a water jug and bank account to explain that, from 'empty', their trust in the PHCP is increased or decreased, depending on whether they perceive their suspicions are allayed or confirmed. Evidence of the trustworthiness of the practitioner and the efficacy of the health care treatment is crucial to this transactional understanding of trust.

The theme thus shows that the men not only use evidence as surrogate indicators of the quality of their health service, but also as cues to the 'quality' of the provider and

of the customer-provider relationship. This is well supported theoretically by the large body of literature on the importance of evidence in services (e.g., Bitner, 1992; Zeithaml & Bitner, 1996). Moreover, this theme suggests that these men conduct quality checks on the provider and the relationship at particular times throughout the relationship, triggered perhaps by feelings of dissonance associated with negative evidence. It is plausible too that in relationship, the customer not only experiences cognitive dissonance but also forms of emotional and/or relational 'dissonance', when he has a gut feeling (aka the Quack Detector) about the provider or the state of the relationship. Certainly, the Evidence theme indicates that there is a need for further research by services marketing and consumer behaviour theorists into customer experiences of relational quality and satisfaction, consumer evaluation processes during service relationships, and consumer use of behavioural and relational 'evidence' in service contexts (e.g., gendered patterns in the use of evidence by consumers).

There is a strong focus in Evidence on technical competence and results/cure, but particularly at times when the patient perceives his problem has psycho-social aspects then individual participants also use physical evidence in particular as an indicator of the practitioner's competence in 'care' (e.g., Jimmy's comments about finding men's magazines and a "normal" décor – not pink - in the waiting room: "Jimmy went in there and thought well, you know, they actually care..." M#2: 1197). In this way then the men's Evidence theme concerns goal achievement and the competency of the PHCP as a professional health care provider. It relates therefore to role competence, achievement standards, and accountability, which in turn are more likely to maintain relational separateness than foster connection.

These features of the theme provide links to theoretical work that regards such features as classically masculine according to the traditional normative guidelines for male-ness (e.g., Annandale, 1998; Broom, 1998; Cameron & Bernardes, 1998; Palan, 2001; Palmer & Bejou, 1995; Smith, 1998b). These same features are prominent in health care because of its foundation on the biomedical model of health and illness (e.g., Dew & Kirkman, 2002; Lupton, 1997, 2000; Oakley, 1993). Therefore qualities and behaviours that meet general social norms for masculinity will be reinforced and perpetuated in health care contexts where the individual adopts the traditional patient role. In addition, the individual male is further encouraged in these attitudes and behaviours by individualism and consumerism, ideologies which emphasise consumer rights, each person looking out for and asserting these rights, assertive questioning and challenging by the individual consumer, and the legal accountability of the service provider (Lupton, 1996). This level of social and cultural endorsement helps account for the gendered nature of Evidence as a theme in the trust experiences of these men.

Understanding the strength of these norms helps us to appreciate the difficulties experienced by the men when they are faced with developing a relationship involving trust. In their collective analysis the men make repeated references to a relationship with a PHCP being a move into “unknown territory” and how uncomfortable this is for them. They talk too about it being “hard” and “scary” trusting a practitioner, and about having to “learn to trust” being “typical” for Kiwi males (W#5:3409). Trust is the beast R. is referring to when he uses the cliché “That’s the nature of the beast” (M#5:2545) during collective work on the process of “learning” trust. Trust requires a

move beyond society's prescribed parameters and the everyday sanctions for traditional masculinity to relatively unknown relational territory.

Their Evidence theme reflects the risks these men perceive in trust and also represents their ways of checking that it is safe for them to be relating outside the normative guidelines for the male as they stretch those boundaries. The men's lived experience and sense of Evidence adds considerable depth to the conception of evidence in the services literature as the physical "tangibles" of service delivery (Zeithaml & Bitner, 1996, p. 516).

Men's Theme: Autonomy

Positioned again in the He domain of the research heuristic, Autonomy is the second of the men's gendered trust themes that is focused squarely on the male patient as an individual, specifically around lived experiences involving self-governance. Because of its direct links to key aspects of stereotyped masculinity the theme's connections with gender are relatively clear and straightforward.

The men bring the theme together using the constituent aspects of self-determinism, knowledge, and voice, and explore it in relation to their socialisation into male-ness, 'Kiwi blokes', and male patients. For instance, according to the collective, males are taught self-control at an early age (e.g., Jimmy's knee) and learn also to be in control of situations (e.g., Brent's diving accident); the Kiwi bloke has learnt to be a Do-It-Yourself expert capable of fixing most anything that breaks (M#2:2243); the male patient will tend to diagnose and treat health care problems himself before

approaching a practitioner for help (M#2:631). Throughout experiences like these, the men learn self-control, self-sufficiency, self-reliance, and separateness are society's valued ways of being masculine. These values are theorised as stereotypical masculine characteristics in the literature (see Cameron & Bernardes, 1998). So, at this point we can appreciate the trust theme Autonomy as a to-be-expected reflection in the health care context of values that are fundamental to masculinity in the patients' macro context.

A much deeper appreciation of the significance of Autonomy is possible when we look at what happens for these men when they enter patient-practitioner relationships where PHCPs are perceived to be relating from a traditional doctor role in accordance with the biomedical model, and/or the patient is cast in the traditional patient role. Insights to the theme's significance are facilitated by considering Autonomy in the context of a hypothetical, 'pure' biomedical relationship.

In this relational scheme, the doctor has autonomy and the patient has little or none. Therefore, a male who lives as an autonomous self-sufficient individual outside, is expected when he enters this type of health care relationship to surrender, abandon, or suspend a large part of that autonomy to the doctor as medical expert and ultimate decision-maker. In this health care context his autonomy has no value, is inappropriate, and likely to lead to serious role incongruence for him. To deal with this incongruence, the male might decide to exercise his autonomy outside the consultation by not following the doctor's orders or discontinuing the relationship. To avoid this incongruence in the future, the male might wait even longer before seeing a practitioner the next time he has a health problem or become more vigilant (e.g.,

Evidence) about protecting his values in his relationships with PHCPs. While this is a hypothetical scenario (most common these days in relationships with health care specialists, according to the participants), it is plausible that similar issues concerning male autonomy are experienced to varying degrees in real-life health care relationships, in particular those aligned with the biomedical model, where males perceive their autonomy is compromised.

In this way then, we can understand that the normative guidelines for traditional masculinity stress autonomy as a major aspect in the male identity, which goes part way to accounting for its presence in this research as a gendered theme. Beyond this though, the dynamics of lived relationships with practitioners could heighten its salience when male patients perceive it as an aspect of their identity put under threat by their own or the PHCP's assumptions about their respective roles. From this position we can regard the thematic aspects of Knowledge and Voice, with their emphases on The Man as the expert on his health in the context of his life, as representing the commonly experienced ways of exercising and maintaining their autonomy in the participants' patient-practitioner relationships. Thus, the anticipated and lived 'protection' of their autonomy conceivably intensifies its importance as a gendered theme in this service context.

The topics of agency and control, which the men implicate in their experience of Autonomy, are well researched in the nursing and practice development literatures. Within health care autonomy is acknowledged and encouraged as a focus in health practice that respects both the patient's own experience of illness and her/his crucial place in the management of well-being/illness. Agency and control are also growing

research interests within the consumer behaviour, services marketing, and relationship marketing fields. Consumer autonomy is also implicated generally in marketing theorists' long-standing interest in the consumer choice and decision-making processes.

This research adds on to these bodies of knowledge by exploring the interplay of gender and consumer autonomy in consumer-provider relationships. The contribution of this particular trust theme lies in its examination of autonomy, a valued masculine attribute in the wider social-cultural context, in a specific service context which these men reveal by nature of its structure does not always support their autonomy.

Men's Theme: Friendliness

This theme occurs in the 'PHCP as Other' domain of the heuristic, and is care-related. It is telling in its simplicity – it pulls together those attributes and qualities in practitioners that make it easy for the male patient to approach them for help, to build a relationship, and to trust. It signals a practitioner who is 'user-friendly' in other words. These men develop warmth and good humour as specific aspects of the theme. Taken together, these are basic interpersonal skills that the men are identifying and exploring in relation to trust. They are a set of behaviours that, for these men, mean that the PHCP is at ease in relationship, actually knows how to relate with another person. These are important messages to get from the Other when a man might be in a situation where he feels vulnerable and uncomfortable in himself. As we have already seen, men responding to the practitioner from the traditional masculine model are likely to find it difficult to ask for help in the first instance, and to feel threatened and

challenged during the patient-practitioner relationship because of tensions between their position in the interaction and their genderisation.

The Friendliness theme developed by the male participants in relation to their trust, involves some fairly common social warm-up techniques, e.g., the PHCP chatting about “life and...politics” (Brent, M#2:1331), topics which require little or no personal involvement from either person. Their construction of PHCP friendliness also encompasses more personal (but still relatively superficial) talk about the patient as an individual - his work, his family situation. Finally, this friendliness involves some topics and interpersonal behaviour that the men unequivocally regard as gendered: sport in general, rugby and yachting in particular, occasional swearing, and ‘bloke’ jokes (detailed in Chapter 7). The participants find this gendered friendliness reassuring – it conveys the message that the PHCP is on the same side as the patient and implies respect and understanding of his masculine identity.

However, as Forgas (1985) points out, friendly gestures characterise relationships with minimal personal involvement, where the individuals are interacting with each other mainly in terms of prescribed roles. This theoretical outlook fits with the men's apparent predilection for maintaining well-defined roles, particularly for the practitioner. It is possible from this perspective to see that the practitioner's friendliness could actually perpetuate low-level involvement exchanges between patient and practitioner, compounding the difficulties around intimacy and disclosure that are reported in patterns of male relationality.

The gendered nature of the men's Alliance theme can be explained in relation to the traits embedded in society's traditional guidelines for masculinity. These guidelines stress the development of a "separate self" identity for the male, valuing separateness and individual-ness over connection and community (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Jordan, 1997c). This notion of a separate, bounded self set down for males by traditional socialisation is further endorsed by individualism and consumerism with their focus on the supremacy of the individual and the importance of individual rights and entitlements. The masculinity sanctioned by these influential social forces is played out in their patient-practitioner relationships by the men's experience of Alliance as a way of being in relation to the PHCP as Other which preserves their constructions of male Self.

Finally, this theorising at once supports and extends the work done by marketing scholars using agency theory (e.g., Andaleeb, 1996; Bergen, Dutta, & Walker, 1992; Eisenhardt, 1989; Ganesan, 1994; Heide & John, 1988; Morgan & Hunt, 1994) and health care theorists who advocate patient agency and equality in the 'new' relational models for health care (e.g., Coulter & Fitzpatrick, 2000). It extends such research by understanding that the cluster of relational aspects comprising Alliance is more gendered than previously acknowledged. Further insights to the dynamics and implications of Alliance as a gendered trust theme in an inter-personal service context might be developed by examining the management literature on inter-firm alliances.

common goal of dealing to the patient's health problem. There are strong connections between this and the previous gendered themes of Evidence and Autonomy, through the constructs of separateness and individual power. Here, separateness is implied in the emphasis in Alliance on the two individuals as discrete human entities within the relationship, both in their respective roles of patient and practitioner and also in their capacity as individual human beings. This sense of Alliance thus has much to do with maintaining the personal integrity of the male patient as a self-contained, unique individual, as opposed to any sort of 'merging' of the identities of the two people in relationship. Their 'merging' is more impersonal somehow, a shared focus on the task at hand that occurs outside of the two persons involved.

Alliance, as constructed by these men, takes place between team members on a level playing field. It cannot occur within a hierarchy. This means that Alliance is more likely to be experienced in patient-practitioner relationships that are horizontal in nature, and more unlikely within relationships bearing traces of the biomedical model, specifically in the prescribed hierarchical positions of patient and doctor. This indicates a subtlety in how the men perceive 'roles' in their experiences. In the health care context, these men appear to use 'roles' more as a construct to clarify task expectations and responsibilities for each individual, rather than as a prescription for relative power positions. This point is borne out by the men's emphasis on equality between patient and practitioner, on the basis that each is 'expert' on different types of knowledge – the practitioner being the expert who holds specialised technical knowledge relating to health care issues, the male patient being the expert holding expert inside information on his body and the lifeworld in which he lives his experiences of health and illness.

Outside academe, friendliness can be simply the natural response of one human being to another who is feeling awkward or ill at ease. The Friendliness theme developed by the men conveys this meaning through a strong sense of the genuineness and human warmth of the practitioner. The collective understands friendliness in the patient-practitioner context to be the practitioner's ability to relax and reassure the patient, before getting down to business – a sort of relational CRC [brand of household lubricant].

Inherent in the men's construction of Friendliness is a limit to the level and intensity of the connection between patient and practitioner. Their Friendliness stops short of any deep and meaningful dimensions to the professional relationship (experienced by the men in 'Personal Connection' and 'Empathy', discussed earlier under 'Common Trust Themes'). Rather it reveals the importance for these participants of the set of warm-up relational interactions that help to establish a base for the relationship to work from. Their importance is underscored by the men's awareness of PHCP genuineness here, and the highly sensitive 'bullshit detector' that kicks in and works to close down any interaction that they perceive is more mechanical than authentic.

Men's Theme: Alliance

A theme from the 'They' domain of the men's trust experiences, Alliance is constructed by the men using agency and equality as its main aspects. These three key terms of the theme convey its over-riding sense: the men's perception that trust in PHCPs is characterised by their sense of the male patient and the PHCP each separate and with his own 'job' within the relationship, working alongside the other toward the

Gendered Aspects of Trust

There are single constituent aspects in the trust themes that can be considered to be gendered in that they are experienced and articulated by the women and not the men, and vice versa. These are presented in Tables 6 and 7, entitled ‘Women’s Gendered Aspects of Trust’ and ‘Men’s Gendered Aspects of Trust’ respectively.

Table 6: Women’s Gendered Aspects of Trust

Domain	Aspects
Patient as ‘She’	fear, power, Self-expression, silence, dialogue, with-holding truth
PHCP as ‘Other’	assurance, authority, PHCP intuition, emotional detachment, compassion
Patient & PHCP as ‘They’	reciprocal respect, partnership

Table 7: Men’s Gendered Aspects of Trust

Domain	Aspects
Patient as ‘He’	professional intimacy, rapport
PHCP as ‘Other’	technical skill, competence, expertise, experience, professional ‘personal’ characteristics, practice skills, emotional involvement warmth, good humour, perceptiveness, comprehension, openness, genuineness
Patient & PHCP as ‘They’	effort

Regrettably it is impossible to discuss the finer points of overlap between these trust aspects and gender because of space and time constraints. It is interesting and important however to acknowledge these sets - I present them here in the interests of thoroughness and also in the hope that they might be explored in the future.

8.5 Concluding Comments

Patient trust is a profoundly social and relational phenomenon. This research shows that patients' trust experiences with PHCPs are not the products or possessions of individual minds but rich, multi-faceted experiences constructed by human beings in relationship with each other. How individual patients identify, respond to, and interpret their trust experiences varies according to situational factors such as the nature of the health care problem and their health status, but also to their lifeworld, their age, ethnicity, and so on (Jones & George, 1998; Lewicki, McAllister, & Bies, 1998).

This research has revealed certain themes that relate to the trust experienced by the female and male participants across a range of primary health care experiences. These themes thus represent the common patterns of experience in the women's and the men's constructions of patient trust in primary health care practitioners. Within these common patterns the research shows that individuals lived a range of personal variations depending on circumstances. The individual variations on the theme provide it with experiential richness and offer a valuable theoretical breadth.

The social constructionist perspective leads to the conclusion that these participants constructed their trust in PHCPs from a range of discourses. These discourses include those that relate specifically to the health care context and the position of patient, ranging from the traditional biomedical model for relating to the practitioner through to ways of being in relation which characterise alternative health care.

In addition, at different times these women and men related from different broader discourses, such as those based in the ideologies of consumerism and individualism. As this research shows, the participants also lived gender in various forms in their relationships, at times following the traditional norms for female or male, at others relating according to discourses for 'newer' ways of being female or male.

The themes revealed by this research represent patterns to the experience of trust for the participants. The research did not find nor present the trust themes in fixed positions. The participants lived the themes and the constituent aspects of each theme in multiple configurations.

The valence of themes and of aspects changed in response to the needs and perceptions of the individual patient at any given time, what the practitioner brought to the relationship, and the relational dynamics that evolved between them. The actual shape that patient trust took was different from female to male, person to person, person to practitioner, relationship to relationship, moment to moment.

The insights to the trust phenomenon afforded by using social constructionism as the theoretical lens help explain the participants' lived variations on any one theme and the ever-changing configurations of themes into a single 'experience' of trust. Social constructionism also supports scrutiny into the apparent contradictions between some of the trust themes (e.g., the men's themes of Personal Connection and Autonomy) and enables much deeper understanding of trust's complexity. Society's prescriptions for the patient-practitioner relationship and for gender are changing. The constructions of trust detailed in this research reflect these changes in their fluidity and diversity.

By examining the women's themes and the men's trust themes alongside one another, the research has been able to recognise critical points of convergence and divergence between them. In the themes that converge most fully, called the Common Trust themes, there appears to be minimal interaction between gender and the participants' experiences of patient trust in PHCPs. Some interplay with gender is apparent in the set of trust experiences labeled Shared Trust Themes, which recognise differential links to gender at different levels of the patients' trust experiences. The connection between gender and patient trust is seen most clearly in the themes organised as Gendered Trust Themes.

These different gender-trust interactions are represented pictorially overleaf in Figure 1: Trust Themes and Gender.

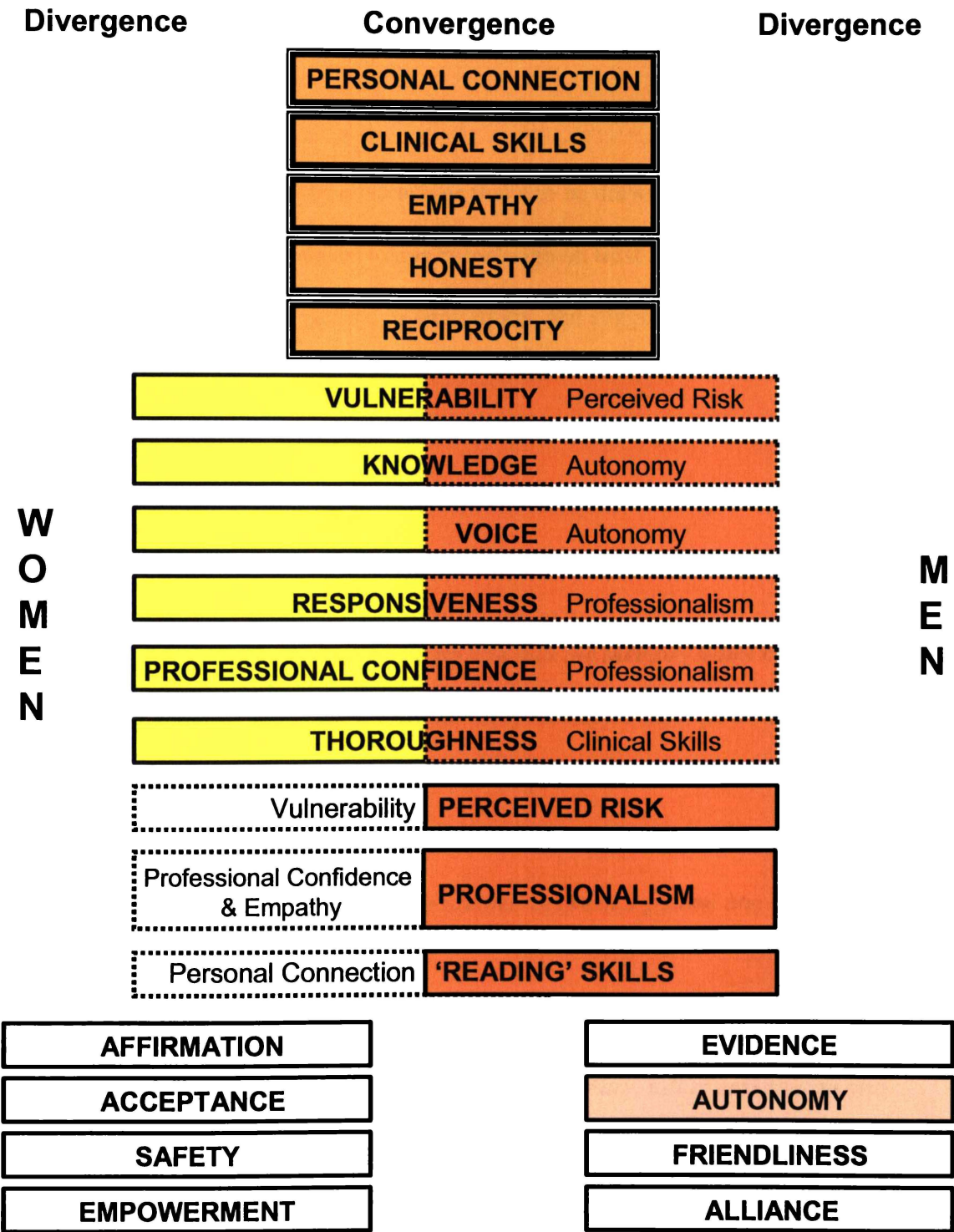
The figure displays the nine Shared Trust Themes using a solid line and capital letters to show a trust facet that was constructed as a major theme.

It uses a dotted line and upper/lower case to show that the facet was configured as a constituent aspect of another theme; in this case, it is the name of the theme in which the facet is configured that appears in the figure, labeled in upper/lower case. For example, vulnerability was constructed as a major trust theme by these women. Therefore, the figure shows it in a solid box labeled VULNERABILITY. The men configured vulnerability as a constituent aspect of their theme Perceived Risk. The figure indicates this difference with the dotted line and lower case.

Moving backwards and forwards from the micro level of individual trust experiences out through the meso level of health care as an institution, to the macro socio-cultural level has enabled us to explore possible explanations for these interactions between participants' patient trust experiences and gender. In this process of contextualisation a patient's trust experience becomes more than simple individual responses of attitude and behaviour toward the practitioner, and instead can be understood as a reflection of the larger social and cultural processes (of which gender is only one) that are woven into our individual actions and our relationships.

Figure 1

Trust Themes and Gender



The insights afforded by this interpretive movement allows us to appreciate that a single trust experience incorporates the broader social context, as well as the aspects brought to the construction by the individuals and their person-to-person dynamics. And so, I hope, we are able finally to begin to understand more clearly how gender shapes patient trust.

In the next chapter I present the conclusions that can be drawn from this research, identify the contributions it makes to our knowledge on trust and gender, discuss the implications of the research, outline its limitations, and suggest areas that could be developed in the future by researchers.

8.6 In My Own Words

PhD fatigue. But under that a wonderful feeling that the Memory Work method has been the right way to explore what Trust actually means for these patients – in all their complexity these narratives show us how they lived Trust and how they made sense of it. And on this very sound base we are really able to move towards a deeper understanding of the phenomenon as it is created between a patient and a practitioner.

The latest PhD dream: I am a younger than I am now Mary, full of enthusiasm and energy, inside a house with my two youngest children. We are ready to go on a big trip, an overseas journey. We three are packed and prepared, ready to head for the airport. But we can't leave yet because we have to wait for an older than I am now Mary, withered and slow, who has left the house with a partner. They are supposed to

be coming with us but they have gone off somewhere and are very late. They're holding us up. It looks likely that we'll miss the plane. Then at last they come in. They close the door behind them – it is cold and blustery outside. They amble into the lounge where we are waiting. Withered Mary moves like Eeyore. She is vacant and doesn't seem to appreciate that they have jeopardised the trip. The younger Mary is really cross and shouts at them.

I woke up from the dream very sure that I had to get this PhD finished – there is another journey to begin. I am looking forward to getting started – just have to wait until old Mary and her PhD partner get home.

9: Conclusions and Contributions

We must die as egos and be born again in the swarm, not separate and self-hypnotized, but individual and related. (Henry Miller)

9.1 Introduction

Trust is an important concept in marketing, yet we have little understanding of how people actually experience trust. Trust seems particularly relevant in the high-risk context of health care services where we have failed to try to understand women's lived experiences of trust, often dismissing its importance altogether.

This study investigates patients' lived trust experiences with primary health care providers. It examines trust and trust-gender dynamics from the patients' perspective. The research insights are relevant for health-care practitioners, policy makers, and consumers, as well as scholars interested in energising research and theory on relationships.

9.2 Conclusions

There are three main conclusions from this research. First, there is a vital relational dimension to trust in the patient-practitioner relationship. Second, because of that relational dimension, the entitative cognitive-affective-conative framework did not fit.

Instead, a relational heuristic emerged from the data. Third, the phenomenon of trust was gendered for these participants.

While theorists recognise that trust is a multi-dimensional phenomenon, they have tended to focus on cognitive, emotional, and behavioural dimensions at the level of the individual. In this study, it quickly became apparent that patient-practitioner trust is a relational phenomenon and extracting the individual from the relationship would not work. Deeper understandings of trust must address individuals' experiences holistically and recognise the importance of relational context and social context in any individual's construction of trust.

This research finds that there are both profound relational and social dimensions to trust. Trust is understood as a relational phenomenon through the heuristic device of the 'She'/'He,' 'Other,' and 'They.' This framework allows for both the idiosyncratic and relational nature of the trust experience. Trust is revealed as a complex, dynamic, and multi-dimensional construct, embedded in the immediate context of the patient-practitioner relationship and in the wider socio-cultural context. It is ever changing and therefore resists modelling. We can recognise patterns, but must understand that these are configured differently - from moment to moment within the experience, from experience-to-experience, and from person-to-person. Trust changes according to the needs and perceptions of the patient at any given time, what the practitioner brings to the encounter, and the relational dynamics that evolve between them.

Trust is gendered. This conclusion highlights the social nature of trust, revealing the interaction of gender as a social process with the individual's construction of the

phenomenon. Gender shaped the ways that these women and men lived and attached meaning to trust in their interactions. Its influence is most evident in the separate themes, such as Safety for the women and Autonomy for the men. Gender is less evident in the trust themes that share characteristics across the women and men (e.g., Vulnerability). Gender is least apparent in the themes that are common to both genders, such as Clinical Skills. This conclusion insists that we acknowledge gender differences, but also that we recognise important gender commonalities. We must move away from positivist dichotomies of gender to understandings that embrace the plurality in contemporary constructions of gender.

9.3 Contributions

This research makes several worthwhile contributions to theory. The first group of contributions relates to the relational nature of trust. The relational framework used to understand this study offers a new way of organising and interpreting human experiences that take place within relationships. It honours each of the people involved, allowing researchers to examine facets of the experience at the level of each individual. Moreover, by contextualising these aspects within the relationship the framework also allows researchers to understand those facets of the experience that belong to the relationship itself – those facets that are expressions of the individuals' relatedness. The framework provides researchers and theorists with a conceptual means to explore the richness of human experience hinted at in the Gestalt wisdom 'The whole is greater than the sum of its parts'.

The relational heuristic device developed from this research offers researchers an analytical tool that preserves the integrity of relational experience. It explores trust

using the domains of ‘She’/‘He’, ‘Other’, and ‘They’ to allow for both the idiosyncratic and the relational nature of the experience. The heuristic in combination with social constructionism can lead to deeper understandings of trust or any relational phenomenon at levels of the individual, the relationship, and the social milieu of their interrelations.

The notion of relational risk in provider-customer relationships, which occurred within the relational dimension of trust for these participants, is a specific extension of the risk literature. From this research relational risk appears to have particular significance for relationship marketing and service marketing because of its obvious implications for customer loyalty, customer satisfaction, and customer retention. The relational dimension and relational risk as they occur in provider-customer relationships therefore are both valuable topics for future research.

Previous researchers have found that trust and gender separately can affect patients’ health care experiences. This research brings the separate concepts together and suggests that marketers should examine the actual dynamics of gender-trust interactions for consumers. Marketers must not treat gender and other social factors as simple demographics.

Other contributions to literature relate to the Memory Work method. This appears to be the first reported research to have used the method for a comparative gender study. Previously, it has been used to research topics using groups comprising one gender only, or mixed gender. This is a significant move forward for the method. Although it

was designed as a feminist method ‘by women for women’, Memory Work has proved robust and productive for comparing experiences across genders.

Its application here also offers insights to gendered ways participants use research methods. I observed gender differences in the content of their Memory Work narratives, the way each group structured their sessions together, and how the women and men accomplished closure for their group in the final session. These insights serve to remind researchers to be aware and respectful of gender as a critical factor in the research processes they manage. Research methods and design must be flexible enough to adapt to gendered needs that emerge during the process, to ensure participants are able to voice their experiences clearly and safely.

9.4 Implications

The relational dimension revealed in this research underscores trust’s relationality and the part played by both patient and practitioner in its creation. This has important and immediate implications for health care practitioners. It adds weight to the mandate for health care practitioners to attend to their relational skills - the ‘care’ skills of the heuristic - and understand the impact that their behaviour can have on trust. The five trust themes that focus on the relationship itself draw attention to the conjoint nature of patient trust, and the need for practitioners to pay attention to the patterns and quality of relatedness that evolve between them and their patients. Practitioners who are serious about helping patients must raise the ‘relationship’ to conscious and careful consideration in order to be able to manage it competently and responsibly.

The large number of trust themes that these participants focussed on the practitioner (14 of the total 27 trust themes) points to the need for practitioners to be mindful of the critical part they play in patient constructions of trust. Practitioners who are aware of their place and responsibilities in constructing patient trust then can take steps to actively generate, sustain, or disrupt relational patterns in the interest of fostering trust.

The five common trust themes have strong connections to notions of shared humanness, and basic human needs and values (e.g., connection, empathy, and honesty), and therefore emphasise the need for primary health care practitioners to relate with patients as one human being to another. The contemporary Western health care context has strong roots in a science of health that alienates the practitioner from the patient, and distances the two from each other as living, feeling human beings. The implication here is that practitioners incorporate in the individualisation of their service conscious efforts to ‘re-humanise’ their interactions to meet patient trust needs that are founded on the notion of shared humanity.

The gendered trust themes represent those facets of trust that women and men live quite differently. PHCPs who respect these differences can be sensitive and responsive to gendered needs and relational patterns in their interactions, understanding that gender, like trust, is not a fixed social status and patients can construct their ‘gender’ from a number of gender orders available today. Practitioners must also bear in mind the effect that their gender can have on the relationship in general, and on trust in particular. This research shows that issues of affirmation, acceptance, safety, and empowerment were critical in the women’s trust. The men’s

gendered trust themes were developed around evidence, autonomy, friendliness, and alliance. These themes are specific facets of trust that were of primary importance for one gender and not the other, and therefore represent areas where practitioners can expect gender to have most impact. It is reasonable to suggest too that this research might provide useful insights to the dynamics of trust and gender as they are experienced by consumers of other professional services, particularly those regarded as high-risk services (e.g., legal and financial services). Clearly, more research into these trust issues in other professional services is required in order to identify the shared patterns and points of difference across contexts.

In the context of primary health care, it must be noted that this research does not offer practitioners a recipe for patient trust. Nonetheless, the trust themes do pinpoint specific areas within the patient-practitioner relationship that are vital to trust according to these participants and therefore exist as signposts for any primary health care practice aiming to improve patients' trust experiences. Taken together the themes could be used by practitioners as a checklist to guide reflection, evaluation, and improvement geared to fostering and/or sustaining patient trust.

For managers and policy makers working in the primary health care service sector, the research reinforces the importance of creating service environments, delivery processes and management structures that facilitate patient trust. Data point to the need for these to be designed and managed to allow both for human relationships between practitioners and patients, and for gendered facets of patients' health and illness experiences. Educators need to stretch health care curricula and establish courses that better prepare professionals to accommodate in their real-life practice the

diversity (including gender) and multi-dimensionality of human health and illness experiences, and the primacy of the patient-practitioner relationship itself. Also, the research shows that practitioners' health 'care' responses are crucial to patient trust, and as such deserve more space on educational agendas.

The research has far-reaching implications for theory across several disciplines. The relational heuristic stands to add considerable depth to all research and theory that deals with human relationships. The framework broadens the research focus from the individual as an isolated unit to take in the relational sphere in which individuals are interdependent. It is in the context of the relationship that an individual's behaviour becomes meaningful.

The relational heuristic provides a theoretical structure in which to explore the patterns of interaction between two (or more) people and the meanings they construct in their relatedness. It does not extricate the individual from the context, nor does it detach the relationship as a unit from the human beings who brought it into being. It follows that the relational dimension is likely to be relevant for all research into 'social' phenomenon. From this relational perspective, gender also can be expected to play a crucial interactive role in social-relational phenomena. Researchers who take gender seriously as a social factor shed light on the complexities of social experience. Given that marketing involves gendered human beings marketing researchers would be well advised to give gender more attention than a tick box.

Finally, this research has important implications for consumers. One of the goals of Memory Work in consumer research is to empower the consumer. The following

story illustrates this consequence. This story is about a patient constructing a new way of living ‘trust’ in a primary health care practitioner. It is about personal reflection on habitual patterns of relationship, hope, agency, and empowerment. It is a story of change. The central character of this story is a woman named Christine. Christine is one of the women who helped me transcribe the audio-tapes for the group Memory Work sessions. She is aged in her mid 60s.

Christine came up to me at the counter of the transcribing service, introduced herself, and with a big grin on her face, told me how she had been “inspired” by the sessions to challenge her dentist. Christine had a long history with this practitioner – “a huge file”, spanning many years and much dental work – and had been reluctant to challenge him before. But she had drawn courage from the participants’ work and, refusing a friend’s offer to accompany her for moral support (an advocate!), Christine had resolved to challenge the dentist on her own: “I was determined to do it myself.” As it turned out, the dentist had responded very well to the challenge. Christine was surprised and gratified. She was extremely pleased that she had chosen, at last, to voice her concerns. And finally, she was looking forward to having a much “better” relationship with the dentist.

Christine’s experience illustrates the value of Memory Work to individual consumers in their normal everyday lives. Thus, this research encourages using methods and examining issues that help consumers understand their consumption relationships and regain some control.

9.5 Comments on Memory Work as Method

Memory Work generated rich, thick descriptions of patient trust, and proved a valuable method for extending theory on trust and its interrelationship with gender. In this regard, the method was entirely congruent with the goals of this research and very successful in producing a store of valuable data.

Gender affected both the way the groups functioned and my role in the groups. My position as a participant in the women's group and as a facilitator in the men's group leads me to suggest that the method needs more detailed guidelines for research situations in which the researcher is a different gender from the participants.

At the conclusion of the research I have some observations and specific suggestions that researchers may want to consider in their use of Memory Work:

- Re-writing: These men 're-wrote' their narratives, as Haug et al. (1987) had prescribed, but re-constructed a collective narrative during the session, finishing off sentences, and taking turns to develop the common, understood story line. The central character of this collective narrative was 'The Man' or 'A Man', or 'Men'. These men did a lot of their re-writing as part of the summarising that they built in to the end of each session. They identified possible main points, then wrote them into the collective narrative to test them for fit, and developed the collective storyline that way. They re-wrote as a spontaneous, natural group dynamic, rather than on instruction – perhaps this exercise could be built into the method as an extension, by encouraging participants to identify main points of commonality

(e.g., by using a whiteboard, an analysis template for group work, and by structuring summary time at the end of each session). This collective ‘re-written’ narrative would seem to be in line with the method’s philosophy and be a more natural, less time-consuming way of formally reconstructing the participants’ individual experiences.

- **Analysis:** Researchers could consider framing a system for recording and organising the Memory Work group’s on-going analysis, e.g., an analysis template, a whiteboard. The men seemed to want to record their main points as they went so that they could ensure that they covered them all. Both the men and the women expressed concern that important points were being lost over the course of the group analysis. This experience suggests that a recording system could make the method more satisfying for the participants, facilitate analysis of the data (for the researcher as well as the participants), and reduce the chances of the researcher mis-interpreting the collective’s interpretation.
- **Researcher Analysis:** Researcher could follow each entry in the analysis catalogue with the initial of the participant who made the quote in order to check if a pattern is being experienced across the group or by one or two individuals only.
- **Extension:** The method could be extended by encouraging individuals to mark points of interest on their copies of individual narratives as the writer reads it out to the group. These notated scripts could offer another level of analysis and confirmability to the method. Similarly, videotaping the sessions or having an

observer present to take notes would enable the researcher to include non-verbal communication in the data.

Naturally, keeping in the spirit of Memory Work, the group should choose how they will function in relation to the overriding philosophy and purpose of Memory Work. These are some suggestions that could be valuable when future groups are negotiating the processes they will use.

9.6 Future Directions

There has been concern for some time over the failing state of health of relationship marketing. Some marketing theorists are convinced the paradigm is in the final stages of decline – that it is dying, in fact. I am convinced that the relational framework used in this research could inject life back into the paradigm. While researchers continue to dissect relationships into separate bounded element-objects for study they will be cutting through the relational interconnections that sustain them. Relationships cannot be lived alone, nor can they be reduced to a simplistic ‘sum’ of its human components. Under such research procedures relationships lose their vitality and the chance for deeper meaning is lost. Relationship marketing scholars need to reconsider the usefulness of research practices that produce limited fractionated understandings of subjects as entities and relationships as instrumental, subject-object structures. The heuristic framework offers relationship marketing one way of examining market relationships that leaves individual actions located within relationship and highlights ‘truth’, or meaning, as an on-going process of relating.

Research ideas triggered by this study include:

- Understanding relational risk: When does it occur and how does it affect the lived experience?
- Links between trust, service quality, and customer satisfaction: What is the relationship between trust and service quality, trust and customer satisfaction?
- Physical Evidence: Patients use physical evidence as surrogate cues for trustworthiness (see men's data, Chapter 7). Do they use the same cues for trustworthiness as they do for service quality? Do the dimensions of perceived trust overlap with those of perceived service quality, or are they separate constructs for which the men happen to use the same cues?
- Understanding other social dimensions of trust: Researchers might like to study the trust constructions of different age cohorts within genders, different cultures (e.g., Maori, Pacific Island, Asian), and conduct longitudinal studies that track changes in trust over the course of particular customer-provider relationships, or particular time-spans in customers' lives (e.g., teenage years, child-bearing years, high risk prostate cancer years).

* * *

My final hope for our work is that it continues to inspire change; be it change in our individual ways of relating to others in our daily lives, change like Christine's in our ways of being a patient, change in primary health care practices to better meet the

needs of patients, or change in our formal understandings of the trust and gender phenomena so that we can understand intellectually what we need to do in order to foster connection instead of alienation. The strength of our community rests on connections through points of commonality; its richness lies in the diversity among us.

9.7 In My Own Words

Now I feel like making some jam. Then maybe dancing.

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Appendix A: Poster Advertisement

VOLUNTEERS NEEDED FOR PhD RESEARCH

University staff are needed for PhD research into gender and patients' trust in their doctor (General Practitioner).

The research aims to fill some of the gaps in our knowledge on trust. We will research trust from the patients' perspective, looking specifically at how patients experience (positively and/or negatively) trust in their relationships with their doctor/GP. The research will also explore the possibility that female and male patients experience this trust differently.

You need to be able to write about your experiences, and to be comfortable discussing these experiences as part of a small group. You will work in a group with people of the same gender, and similar ages and social/cultural backgrounds.

If you're interested in being involved in this research,
please contact Mary FitzPatrick,
after Monday August 6,
Department of Marketing and International Management.
Extension 6273.
Email: marya@waikato.ac.nz

Appendix B: Text for ‘On Campus’ Advertisement

Volunteers are needed for PhD research into patients’ trust in their doctor (General Practitioner).

The research aims to fill some of the gaps in our knowledge on trust. We will research trust from the patients’ perspective, looking specifically at how patients experience (positively and/or negatively) trust in their relationships with their doctor/GP. The research will also explore the possibility that female and male patients experience this trust differently.

You need to be able to write about your experiences, and to be comfortable discussing these experiences as part of a small group. You will work in a group of the same gender and similar cultural backgrounds.

If you’re interested in being involved in this research, please contact Mary FitzPatrick, Department of Marketing and International Management.

Extension 6273. Email: marya@waikato.ac.nz

Appendix C: Text for ‘Events’ E-Flyer Advertisement

“Research about visits to healthcare practitioners”

For my PhD I am researching the perspectives of men and women on their interactions with healthcare practitioners, and need men and women to take part in this research. If you would like to be part of this project and have a health story to tell, then please contact me for more details. If you know of anybody else on campus who would be interested please pass on this information.

My name is Mary FitzPatrick – ring me on extension 6273, or email me on

marya@waikato.ac.nz

Appendix D: Research Information Booklet

Project Information Booklet

PhD RESEARCH
Mary FitzPatrick

Gender and the Experience (Positive and/or Negative) of Trust between a Patient and a Primary Healthcare Practitioner

1. Who are the researchers and how can you contact them?

Mary FitzPatrick is conducting this research as part of her PhD study, through the Department of Marketing and International Management, University of Waikato, Hamilton. All inquiries and/or problems regarding this work should be directed to Mary. She can be contacted as follows:

Home: 19 Stanley St
Claudelands
Hamilton
Phone 855-1300 (Leave a message if she is not at home)

Work: Management School Building MS5.08
Waikato University
Phone 856-2889, ext 6273 (Leave a message if she is not at work)

Email: marya@waikato.ac.nz

Mary's PhD supervisors are:

Dr Lorraine Friend
Dept of Marketing and International Management
Email: lfriend@waikato.ac.nz
Phone 856-2889. Ext 8982

Dr Carolyn Costley
Dept of Marketing and International Management
Email: ccostley@waikato.ac.nz
Phone 856-2889. Ext 8648

Dr Peter Enderwick
Dept of Marketing and International Management
Email: ipe@waikato.ac.nz
Phone 856-2889. Ext 8644

At any time throughout the project, if you would like to talk to someone other than the researcher (e.g. to make a complaint), please feel free to contact Mary's Chief Supervisor, Dr Friend, as above.

2. What is the project about?

This project describes and analyses your experience (positive and/or negative) of the trust relationship you, as a patient, have with your primary healthcare practitioners. These are the health professionals you can choose yourself to go to, without needing a GP's referral. These professionals include GPs, dentists, and physiotherapists, as well as chiropractors, osteopaths, and alternative healers.

The research will explore how women and men understand and experience this trust, particularly how society influences the way you experience trust in your relationship with your healthcare practitioners.

Specifically, the research will examine:

- How you and others of your gender define and describe your trust (positive and/or negative) with healthcare practitioners
- How you experience it cognitively – what thoughts you have at the time
- How you experience it affectively – how you feel at the time
- How you experience it behaviourally – how you behave at the time

The research will use a method called Memory Work. This method is based on stories written from memory, which are then discussed in a group session.

There will be at least two groups (there may be more, depending on the number of people who take part) involved in the study, working in separate groups of women and men. Because part of the research focuses on the gender experience of trust, you will work in one of the men's groups or the women's groups, depending on your gender.

Before the research begins, Mary will explain the method to all the participants and answer any questions about the research. Then Mary will join one of the female groups as an equal participant. A key characteristic of this method is that the researcher becomes a participant, and all participants are considered co-researchers. Mary will help to set up any other women's group(s) and the men's group(s), but will not be a full participant in their work.

3. What will you and other participants have to do and how long will it take?

You and three to five other people (females if you are female, males if you are male) will meet regularly until the end of the year in "memory-work" sessions. It is anticipated that the groups could meet up to 7 times, generally every 2 to 3 weeks, with each session lasting between 2 and 3 hours. Mary is planning to have this group work finished before Christmas.

You will meet at a time and venue that suits all the members of your group.

At least one week before each session, you and the other participants will write a memory story on a “trigger” topic. All trigger topics will explore particular times when you experienced trust or the breakdown of trust with a healthcare practitioner.

For each session you will be asked to write a different memory story, which will be discussed by the group. Your group will decide on the trigger topics you will write on.

You need to write your stories according to these ‘rules’ or guidelines:

- Write your story about a particular episode, action, or event.
- Write each story using a fictitious name (a pseudonym) and in third person (‘he’, ‘she’, ‘they’). That is, describe the specific episode from the viewpoint of an outside observer.
- Write one of your most “vivid” memories on the trigger topic.
- Write your memories in as much detail as possible, including information that may seem trivial or inconsequential. Include key images in your story – describe the sounds, smells, what you saw, the individuals, behaviours, actions, and the discussion that occurred.
- Write without interpretation, explanation or biography. That is, write your memory without rationalising or justifying why things happened. Don’t use past events to explain consequences or the events in your memory.

Mary will collect your story from you a day or two before each session and organise all of the stories so that they can be easily read and compared during the session. You will receive a copy of each person’s story (including your own) at the beginning of each session.

During the session you will read all the stories written by the members in your group. The group will then reflect upon and discuss the stories. During each session, each group will go through the following steps:

1. A participant reads his/her story aloud.
2. After the story is read aloud, the other group members ask questions to:
 - a) get more detail about the experience;
 - b) fill in missing gaps in the story;
 - c) identify generalisations, contradictions, patterns, underlying assumptions, and dominant cultural values and norms in the text; and
 - d) recognise key elements and insights into your experience of trust with the healthcare practitioner.
3. Once a story has been read aloud, questioned and discussed, then this process (i.e. Steps 1 and 2) is repeated. Another person reads aloud his/her story, and the group members direct questions to the author.
4. The group collectively analyses the stories that have been read so far. In comparing the stories the group identifies differences, similarities and contradictions between the stories.

5. Another person reads his/her story, the group asks questions, and then that person's story is contrasted and compared to those already discussed. This is repeated until all the stories have been examined.

There are two goals of memory-work. One focus is on you as an individual and your personal stories, and the processes you use in your understanding of trust with a healthcare practitioner. A second aim, this time of the group analysis of the memory stories, is to understand the processes that make a "common" sense, or a common understanding, of the trust described.

To do this, you will look for similarities and/or patterns across the stories. As the discussion develops your group will also look for differences among the stories, as well as things that we may take for granted with respect to trust, contradictions, absences, and inconsistencies in individual stories. You will move back and forth from analysing individual stories to analysing the group's set of memories. In this way, your group is striving to uncover the meaning captured in the stories, in order to reach new understandings of the trust phenomenon.

In these memories you will be looking for things that society is telling us, things that we have taken for granted, underlying assumptions, and cultural norms that have occurred about patient-practitioner trust. Thus, the group is trying to uncover the social meanings for females and for males of the trust experience described in the stories; and how those meanings have been created. At some stage during the group session, a coherent picture will emerge and the analysis of the stories for that session will be complete.

4. How will the information collected in these memory group sessions be used?

First and foremost, the data will be used in Mary's PhD dissertation. It is also anticipated that several publications and conference presentations will result from this work. Individual's names and/or identities will not be documented or made publicly known at any point (see details below).

5. What degree and kind of confidentiality and anonymity will be provided for you and the other participants?

To ensure confidentiality, you will use a fictitious name (a 'pseudonym') for yourself in your stories, and will use that pseudonym during the group sessions. You must also use pseudonyms for your healthcare practitioner and any other people mentioned in your stories or subsequent group work. For total anonymity and confidentiality you must also change any street names, the names of suburbs, towns, or cities. You will refer to the other participants in your group by their pseudonyms.

In all transcripts, each participant will be identifiable only by their pseudonym, and in any discussion with my supervisors, personal notes, and analyses I will use these same pseudonyms. At no time during data collection, analysis, or the writing up stage

of this research (either in the dissertation or related publications) will you be identified by your real name.

If you know another participant personally outside of this research, you are free to choose to continue with the project (working in the same or separate groups), or withdraw from the project completely.

The following procedures will be used to protect your anonymity. Each participant's memories will be marked with his/her pseudonym, not his/her real name. Since it will be obvious during the sessions who has written each memory, group members will be asked not to discuss any sensitive personal issues or to connect names to others' stories outside the group.

During or at the end of each session, you may request that certain information remains confidential to the group or not be used in the reporting of the research.

All sessions will be audiotaped. Sections of the tape will be transcribed verbatim either by Mary or a reputable transcriber. The fictitious names used by participants (rather than personal names) will be attached to the transcripts. Upon request, you will have access to the transcriptions and may request that certain personal sections not be used.

Since lengthy excerpts are most likely to be used in reporting of this data, you will be invited to read and comment on any relevant sections to ensure that you cannot be identified in any way that would be objectionable.

This also gives you the opportunity to question any analysis of your personal statements that you believe the researcher has misinterpreted.

6. How will the tapes and information collected be stored and disposed of to ensure your and other participants' privacy?

All consent forms, written memories, tapes, transcripts, and computer disks will be stored and locked in Mary's office or home files. When a transcriber has access to the tapes, they will be similarly secured to ensure privacy and safety.

Upon completion of this project, each of the original written stories will be returned to the individual, and audiotapes will be erased or destroyed. The remaining data will be stored indefinitely. This will enable Mary to use the data in future work, which will extend our understanding of trust in the healthcare setting.

Discussion sessions will be considered the property of the specific group's members and the principal researcher. Upon request you may have access to your group's transcripts, but would be required to keep them confidential and return them to the principal researcher.

If you subsequently wish to use any stories, comments or quotes resulting from the group discussions, you must first obtain the consent of the other group members and the principal researcher. However, personal written stories will be considered personal property of each individual. Thus you will be able to use or dispose of your own written stories accordingly.

7.What will you gain by participating in this research project?

While there is no monetary payment for your participation, it is hoped that these memory-work sessions will be both a social and a learning experience for you and the other participants. Other memory-work groups have reported that sharing, discussing and theorising their memories have been both enjoyable and valuable in understanding how we interact, experience and give meaning to our social worlds. In doing so, perhaps you can achieve a better understanding of yourself and the events in your life, and thus improve the quality of your life and others through your decisions and actions.

8. What if you find the memory work upsetting at any time?

It is possible that you might find the memories upsetting at times. It is in your interest that you understand this and think about how you would deal with this possibility. You need to think about your own personal support network, in case you find that you need to talk about your experiences with friends, family, or professionals.

The group process provides opportunities to work through any possible painful memories to a satisfactory outcome. The process will also have a debriefing component built in, with times for debriefing at the beginning and end of each group session.

You can contact Mary at all times to discuss the research. You can also contact Dr Lorraine Friend in case you feel you would like to discuss anything with a person other than the principal researcher. If you felt you would like to talk to a professional counselor, it would be in your best interests to do so. As a University of Waikato staff member you are entitled to use (free of charge) the counselors available through the Employee Assistance Programme. For details, contact Human Resource Management Division, extension 4003.

9. What is your role as a participant in this research?

You will be a co-researcher in this study, an 'expert' in the experience of trust in a healthcare practitioner. You will be on equal footing with all other participants, working to create a more accurate and deeper understanding of the experience of trust (or breakdown of trust) in a healthcare practitioner.

As a participant, you need to be:

- Willing to join in an open-ended, qualitative research process that is dynamic in nature.
- Willing to commit the necessary time and effort.
- Willing to have the discussion tape-recorded and all the data (stories and transcripts) used in a doctoral dissertation and publications.
- Able to work as a contributing member of a group – it is important that you have good group skills.
- Able to articulate your experiences as a patient – the more fully you can describe your experiences the better. You need to be able to describe your experiences in writing, and then later discuss them with the group.
- Comfortable with reflecting on your experiences in a group setting – having other people question you for more detail, and ‘dissect’ what happened to you.

Notes:

Appendix E: Profiles of Participants

The following profiles give background details of each of the participants plus their self-assessment of their health status at the time of the research sessions.

MALE PARTICIPANTS

Brent

Aged 53. University lecturer. Primary school teacher for 25 years. Lived in Canada for one year. Pakeha New Zealander. Female partner with one teenage son; three grown-up children. Born and brought up in rural area.

Health Status: “I am in very good physical health. I do not visit a primary health provider for anything of concern. I do not experience anything more than a common cold or flu and my fitness I would classify as good considering my age and work environment. Similarly, my social health is very good. My relationships with partner, family, work colleagues, are very stable and satisfying. My emotional health is very good. My ability to cope with my home and work life is as high as it has been for some time so there are no problems to grapple with. Overall I would classify my health status as very good at this time.”

Dave

Aged 40. Female partner, one son (11). Pakeha New Zealander. Residential caregiver for intellectually disabled adults. Drama school graduate, has worked in theatre and opera. BSocSc.

Health Status: “No major on-going health problems. Asthma occasionally, seems to be triggered by physical exertion, controlled with asthma reliever (not preventer).”

Jimmy

Aged 30. Employed in management position at city authority. Female partner. No children. Pakeha New Zealander. Born in Auckland, raised in cities (Christchurch, Wellington, Rotorua, and Auckland) throughout New Zealand. Some undergraduate/tertiary courses.

Health status: “Of good ‘general’ daily health with no current ailments. Rarely need to visit GP. Take a heart drug to slow down pulse rate (Nadalol) and will start a round of Lycopodium prescribed by a naturopath for hayfever.

Various health problems, such as lack of energy and raised heart rate, have been diagnosed/confirmed [immediately after the Memory-Work sessions finished] as a disease called Mitochondrial Encephalomyopathy Lactic Acidosis and Stroke-like episodes (MELAS). This disease encompasses exercise intolerance, inability to convert food energy to muscle movement, the build-up of used cells in organs (including the brain), heart anomalies, progressive organ dysfunction and deafness,

and risk of stroke-like episodes, among many other associated dysfunctions that can occur.”

R.

Aged 44. University lecturer. PhD. Single, no children. Born and bred in England.

British/New Zealand citizen. Lived in New Zealand for eight years.

Health Status: “Healthy, on the whole, apart from occasional visits to GP down the years, for the usual complaints. However, over the last year I have visited numerous healthcare practitioners in an effort to find a cure/relief from the onset of a severe tinnitus in one ear. Was consequently mildly depressed, and fighting a private battle for my own sanity.”

FEMALE PARTICIPANTS

Amy

Aged 38. Senior university tutor. MEd, BBA. Male partner, two daughters (ages 3 and 6 months). Born and raised in the USA. Lived in New Zealand for 7 years; New Zealand citizen.

Health Status: “No major health problems. Generally very good state of health. Have pretty much recovered from birth of second child, six months ago. No major complications from birth. Have recently had a bout of mastitis.”

Emma

Aged 31. University administrative staff and part-time university student. Male partner. No children. Pakeha New Zealander. Born in Fiji, raised in Fiji and Malaysia. Returned to NZ at age 13.

Health Status: "My assessment of health is based mainly on the physical, emotional, social state of Emma at the time of the research.

I was feeling worn out, tired, lethargic, anxious, overweight and depressed. I'd just recovered from a bout of chicken pox as an adult, which I felt had knocked the stuffing out of me. I felt like I needed a break, away from everything, a feeling of totally wanting to absolve myself of responsibility, any kind of responsibility and just walk away from it all, because I couldn't deal with it.

Emotionally, I was pretty fragile, although I tried desperately not to show that outwardly, particularly at work, because I felt I needed to maintain a modicum of professionalism, and it was not going to help my employment if I was falling to pieces every five minutes. There were times though, when I heard staff complaining about not getting a pay rise, or not being able to take a holiday at a particular time in the year, and inwardly I was thinking "Get a life!", or "You don't know how lucky you are that that's all you've got to worry about!"

I'd lost two members of Mum's family in a horrific car accident at Easter, when they were travelling to a family reunion. I was quite close to my great aunt (my

grandmother's sister) since my grandmother's death from cancer, so her death in tragic circumstances had been a huge blow.

I had been and was still on anti-depressants. I hadn't sought any counselling. I was on tenterhooks nervously anticipating news of my husband's impending biopsy test with a neurologist – his health was always in the back of my mind, and thinking about the implications for our life as a whole.

In terms of use of primary health care providers, that list expanded to included not just our family G.P., but included in relation to my husband's health, seeking advice from a neurologist/specialist.

I had also used alternative health care - such as osteopaths, and chiropractors. I think the way I reacted to health care providers and particularly the family G.P. was as a tool or linkage to other services that I may need to use. I probably am still a little reticent toward alternative health care providers, but I appreciate that they have a place in health care services that I might need to seek out.

Due to my husband's health condition, I questioned the action or remedies primary health care providers gave, and wasn't afraid to change circumstances if I was uncomfortable with the way things were progressing.

Socially, I was withdrawn. I didn't want to engage in anything much socially, other than visiting close family. I became hermit like, and insular.”

Jane

Aged 40. Part-time university tutor. Also works for government department. LLB degree. Male partner (engaged). Three children (ages 7 to 10), who stay alternate weekends. Pakeha New Zealander. Urban upbringing.

Health Status: "Recurring sinus and abdominal problems. Health generally good but 'bad days' occasionally without warning."

Louise

Aged 47. University student (previously university tutor, partner in health care clinic, journalist, primary teacher). Divorced. Five children (ages 9 to 20), two youngest at home. Pakeha New Zealander. Parents shifted throughout New Zealand for father's career, so spent childhood in both country and city areas.

Health Status: "Enjoy good health. Have had migraines since I was a teenager, but now manage those with self-administered injections – very successful – I no longer consider them a health problem. Have a well-established relationship with my GP, who treats my children and me when we have what I think are medical problems. We have had regular contact with him over about nine years, mainly to manage the children's asthma. This contact is becoming less frequent as the children get older. We also use chiropractic and naturopathic healthcare."

Melissa

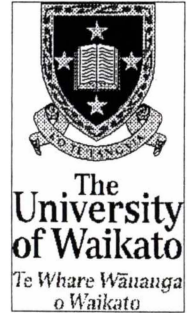
Aged 42. Part-time university tutor, full-time law student. Previously worked for 15 years as a registered nurse (trauma clinics) in south-west USA. Divorced. Four children (ages nine to 18). New Zealander. Rural upbringing.

Health Status: "No health problems."

Appendix F: Covering Letter

Department of Marketing and International Management
Waikato Management School
The University of Waikato
Private Bag 3105
Hamilton
New Zealand

Telephone 64-7-838 4725
Fax 64-7-838 4352
www.mngt.waikato.ac.nz



<Name>
<Address>

6 August 2001

Dear

Re: PhD Research

Thank you for your interest in this research – I'm sure it's going to be an exciting and valuable study.

The Project Information Booklet enclosed will give you an outline of the research, the expected time commitment, and ethical considerations. (I will give participants more details on the research later, in a personal meeting and at a group briefing.)

I will contact you in a few days to find out if you would like to go ahead and take part in this research. If after reading through the booklet, you decide that you would like to be a participant I will need to meet you personally to answer any questions you might have, and to get more details from you so that you can be placed with the appropriate group.

I am planning to have each group get together for the first time later on this month, to meet one another and to be briefed in more detail on the research. We can then begin the research work in early September.

I am including a map of the campus to show you where my office is. Here are the written directions: Come down the steps from Hillcrest Rd through the Management School quadrangle, go past the Cafedemic student café on the left, take the next lane on the left, then walk down the steps to your right, turn left and follow the corridor around to the entrance to MS5 on your left.

Looking forward to meeting you.

Thank you.

Mary FitzPatrick

Extension 6273
email: marya@waikato.ac.nz

Appendix G: Group Collection of Narratives for Men's Session 2

MEN'S HEALTH RESEARCH GROUP

NARRATIVE #2

"The first visit to a new GP"

Trigger 2: “The first visit to a new GP”

Brent’s Narrative

Brent was fed up with his current GP. It seems that each visit was going nowhere. He felt that he had never gone to the doctor in the past for anything that did not require attention or at least an expert opinion. He considered that a doctor’s time was far too valuable to be wasted on things like colds, cuts and scratches. And anyway his body had always looked out for itself in the past with no real problems.

The last visit had been meant to explore emotional issues but Michael Cartwright had been so intent on physical issues that the opportunity to get on to what Brent really went for was difficult. The routine checks of pulse, blood pressure, weight, height, etc., all produced familiar results.

“You’re fine. There are no indications of any problems. Your blood pressure is very good for your age. Are you still exercising regularly? When did we last test your cholesterol and prostate?”

All the routine questions and probes that resulted in the same old responses and conclusions. Brent had done enough of his own reading, and he felt that he was intelligent enough, to know that this time his concerns were not physical. He had felt for a long time that fitness is not only about the physical but also emotional, social, cognitive and spiritual. So when Michael indicated that the consultation might be nearing an end, Brent had to try to lead the discussion into talking about his emotional fitness. After all Brent had asked for two time blocks for this consultation so he was

not going to leave and pay without having used his allocation. He had been to this medical clinic before and talked to a doctor about depression but not Michael and this depression seemed 'deeper' than anything he had experienced previously.

Brent's long marriage was in turmoil and he had moved out of home after nearly 30 years of marriage. Michael had been a stable part of his life for the previous 10 years, although visits were infrequent. Brent didn't know if he could talk with Michael about the 'real' things that were happening in his life simply because of his manner and attitude. Brent had to push Michael hard to finally get a referral for psychological help. This was the finish for Brent. He decided then and there to find a new GP.

Brent had been told about a new GP in the city some time before this latest visit to Michael. On a visit to Paul Harris, a physiotherapist, their casual conversation about anything and everything lead to discussing primary health providers. While Paul worked on Brent's neck muscles Brent mentioned that he was not happy with his current GP and that he was thinking about finding a new one. Paul had recently heard of a younger doctor in town. "I've heard really good things about a new doctor. He is younger so I don't know how you feel about that, but a friend has told me he is really on to it." Brent was asked not to mention that Paul had suggested this doctor as it may be considered unethical. Brent gave the suggestion some serious thought.

Brent phoned the Lisbon clinic to inquire about opportunities for new patients. "No problems," he was told, "when would you like an appointment?" So, after hearing all the details that would need to be completed to be able to transfer, he made the first appointment. Another busy waiting room. Everything seemed typical of all

the previous clinics Brent had been to. Then he was called and met by the new doctor.

Wayne Brown seemed immediately different. “Brent Gordon Halliday. Hi. What do you like being called? Brent, fine. My room is down here. Let’s see if I can help.”

Wayne exuded the qualities that Brent had never experienced with a doctor. He was: Friendly - interested in Brent as a person and what life has for him. He wanted to know as much about Brent as he could on this first visit and he related quickly through issues of fitness and professionalism in work. He wanted to know about his previous experiences with doctors in a professional way.

Open - wanting to talk about himself as well as find out about Brent. He made it clear that a doctor’s job is often very challenging so he often needed to refer to other sources before he drew any conclusions, showing his acceptance of the knowledge explosion that faces all professionals in their work.

Warm - sitting in an open situation, fronting up to Brent, rather than behind a desk or pile of ‘busy’ books and information. He chatted socially before he got onto the reason that Brent had changed doctors. They talked about life, family, politics, rugby, exercise, ... all sorts of issues.

Honest - wanting to know why Brent was changing doctors and what information his previous GP had that he could apply for access to. He asked lots of questions and

declared his difficulties as a GP trying to make sense of all medical issues and the many sources to access for new information, including the Internet.

Down to earth - never pretending to be anything more than a hard working doctor who would do his best for Brent. Right from the first visit Wayne had summed Brent up and judged that it was okay to share a joke and swear a bit on the side.

Brent left that first consultation feeling more relaxed than he had ever left a doctor's room previously. He felt there was an empathy, something this younger man had been able to capture in the very first meeting. On his way out Brent signed the necessary papers to have his documents transferred across from Michael Cartwright, paid for this visit, and confirmed his next consultation time.

Trigger 2: “The first visit to a new GP”

R.’s Narrative

R. had been suffering from an annoying ear noise problem for some three or four weeks when he decided he should visit the doctor. However, since he was relatively new to the area, he didn’t have a GP and needed to find one fast. Not just any GP would do though, because intuitively he felt that this was a slightly unusual complaint that would require a good one. So rather than pick one out of the telephone book, R. decided to track down the name of a lady GP his Mother had been to see during a visit some eighteen months previously. All he could remember about this GP was that his Mother had been very impressed with her, and that she worked out of a nearby clinic. Following a number of telephone calls, R. finally located Dr. X., who had (as it turned out) switched clinics since his Mother had seen her. An appointment was made for later on that day.

The clinic was a new one near a newly developed housing estate in a city suburb with plenty of parking and brand new facilities. It went through R.’s mind that this was a good sign of the standard of care he would receive, i.e. the idea that modern facilities suggested up-to-date practices delivered by highly trained professionals. Having completed the paperwork necessary for signing up with a new GP, R. sat in the clean and tidy waiting room, full of confidence that Dr X. would prove to be a good choice, and hopeful that she’d be able to quickly diagnose the problem and recommend a course of treatment that would do the trick.

As soon as she came out of her surgery to call R. in as her next patient, R. noticed Dr X. was much younger than he'd expected. For some reason this immediately unsettled him. But then he reassured himself by thinking that maybe a sharp young doctor was preferable to an older "crusty" doctor who's set in their ways...but then again, maybe not.

Once in the surgery, the young Dr X. went through the drill of asking all the necessary questions to find out what was wrong. She then checked R.'s blood pressure and pulse, as well as looking inside his ears, nose and throat. R. had expected this routine and felt comfortable about it, although he was a little concerned by the "textbook" manner with which it was being carried out. "Perhaps she really was young and inexperienced," R. thought to himself. Certainly, his confidence in her ability was beginning to concern him again.

After a thoughtful pause, the doctor finally got around to making her diagnosis, and R. focussed his concentration on listening to her every word. "Well, I have to say, I've never actually come across anything like this," she said, somewhat apologetically, before going on to explain that she'd only ever heard about tinnitus, and that she knew almost nothing about it! R. was dumbstruck at this response. Even his friends and colleagues had known of people who had had it – all of which suggested that either she was indeed very inexperienced or that his was a genuinely unusual case – surely not! "What a waste of time this had been," he thought to himself. Dr X. then went on to say that anything to do with the ears required a full investigation, and she therefore recommended that he saw an ENT specialist, offering to book him an appointment on the spot if he wanted. R. agreed, partly because he

was worried it might be serious, and partly to terminate his session with Dr X. a.s.a.p.

Dr X. picked up the phone and booked the appointment for later on that evening at the hospital. As R. left the clinic he'd decided not to see this GP again.

Trigger 2: “The first visit to a new GP”

Jimmy’s Narrative

Jimmy and his wife decided to move to a new city. This exercise was not new to him as when he was young his family moved around a lot. This time however Jimmy needed to find a new doctor himself. He asked his current doctor for a recommendation but the ‘procedure’ was to find one and request the files to be sent.

Jimmy was concerned, as finding a doctor who he and his wife could trust was difficult. Jimmy and his wife were not the type to see the doctor unless the problem was serious, so being able to find a good GP was important. Asking around did not inspire Jimmy any more than throwing a dart at a map.

The choice was made by simply driving past a clinic that looked clean and organised. A phone call confirmed after hour’s shifts were standard. This seemed like a good idea to Jimmy at the time.

THE FIRST VISIT

Parking wasn’t a problem. Which Jimmy thought was good as the last thing he needed while feeling like ‘death warmed up’ was having to figure out which finger to display to other motorists. Entering the building he found there to be a lot of space, without the horrible pink décor some doctors waiting rooms and hospitals felt compelled to display, as thinking back to a TV documentary on prisons and pink

having a soothing psychological effect, the warmer colours made Jimmy feel a little more at ease.

After reporting to the front desk Jimmy sat down in a comfortable chair. Another surprise was the lack of woman's magazines and plenty of male orientated ones. "About time," Jimmy thought. Still feeling well under the weather Jimmy elected to stare at the ceiling. The room was large with three pillars and a curved roof made from corrugated iron. Simple but effective thought Jimmy. Thinking he had the usual 1 hour fifteen minutes Jimmy finally picked up a magazine to read. However this was short lived, as Dr Moose called his name.

Apprehensive about seeing Dr Moose, Jimmy gave his symptoms and awaited the response. Prodded, listened to, temp taken and ears checked, and the usual reading of the notes before deliberation. "Allergic to any antibiotics?" "None that I know of," came Jimmy's standard reply. Exiting with an empty wallet and a bottle of pills Jimmy went home with his medication and a certificate for his work absence. Feeling adequately dealt with but concerned there was no effort made to 'get to know Jimmy' he felt undecided as to whether he would return to the same GP again.

Trigger 2: “The first visit to a new GP”

Dave’s Narrative

Dave has been feeling really tired and has had a sore throat for a week or so. He left it until the moment he saw his pee come out a nearly-brown colour, before deciding he’d better book an appointment at the uni student health clinic.

The waiting room in the reception area looks a bit run down; worn carpet and faded curtains. The building’s a 1950's era prefab that’s been extended – lots of wood veneer panelling. A poster warning about STD’s adorns the wall, and assorted brochures flop over in the slotted wooden holder on the wall. The atmosphere’s comfortably casual, like a hobbled-together service put together on a shoe-string budget could be expected to look.

After a half hour the doctor calls his name and motions Dave in.

He’s man in his early 60's, at first glance a bit formal and conservative. He wears braces, and a striped shirt and tie. Probably someone who close to retiring and only doing this job because he’s no longer capable of running his own practice.

But Dave soon notices that there’s a sparkle in the doctor’s eyes, and that he has a lively turn of phrase. He finds himself nearly laughing a couple of times during the examination, including while the doc’s peering into his throat getting him to say “Ah.” This guy could be a comedian in his spare time.

“In my considered opinion, you’ve got yourself a dose of the dreaded kissing disease, me old boy.”

He smiles at Dave’s bemusement.

“Glandular fever. It’s very common amongst the student population. You’ve either been kissing too many pretty gals, or eating at the student café. For your sins, your tonsils are now oozing out lovely little white globules. And, I’m afraid, judging from how you’re looking around the eyes, I wouldn’t be surprised if you’re about to have a nasty brush with the Yellow Peril.”

A chortle at Dave’s nonplussed expression.

“Glandular fever often infects the liver: we call it Glandular Fever hepatitis. You’re already starting to look jaundiced to me. But don’t worry, you won’t die... well, not for a few decades yet... with a bit of luck.” He chuckles at his own joke.

He fills out a blood test form and tells Dave he’s going to need bed rest for at least two weeks, and will probably have to take it easy for the next couple of months. The good side is he’ll miss out on having to go to any lectures. The bad side – strictly no alcohol. And avoid too much fat or oil; his liver won’t be able to manage it.

“See the nurse on the way out for another appointment next week, I’d like to check I’m right and that you’re not dead by then.”

Dave leaves the clinic still feeling ill, but with a spring in his step.

Appendix H: Consent Form for On Campus Volunteers

Participation in the Study: Gender and the Experience (Positive and/or Negative) of Trust between a Patient and a Primary Healthcare Practitioner

I have read the Project Information Booklet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researcher under the conditions of confidentiality set out in the information booklet.

I wish to participate in this study under the conditions set out in the Project Information Booklet.

Signed: _____

Name: _____

Date: _____

Signed: _____

Researcher: Mary FitzPatrick

Date: _____

RESEARCHER'S NAME AND CONTACT INFORMATION

Mary FitzPatrick
Department of Marketing and International Management
University of Waikato
Private Bag 3105
Hamilton
Tel: (07) 856 2889, ext 6273
Email: marya@waikato.ac.nz

**The Waikato Management School Ethics Committee, University of Waikato, has approved this
research**

Appendix H: Consent Form for On Campus Volunteers

Participation in the Study:

Gender and the Experience (Positive and/or Negative) of Trust between a Patient and a Primary Healthcare Practitioner

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I wish to participate in this study under the conditions set out in the Project Information Booklet.

Signed: _____

Name: _____

Date: _____

Signed: _____

Researcher: Mary FitzPatrick

Date: _____

RESEARCHER'S NAME AND CONTACT INFORMATION

Mary FitzPatrick

Department of Marketing and International Management

University of Waikato

Private Bag 3105

Hamilton

Tel: (07) 856 2889, ext 6273

Email: marya@waikato.ac.nz

**The Waikato Management School Ethics Committee, University of Waikato, has approved this
research**

Appendix I: Consent Form for Off Campus Volunteers

Participation in the Study:

Gender and the Experience (Positive and/or Negative) of Trust between a Patient and a Primary Healthcare Practitioner

I have read the Project Information Booklet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researcher under the conditions of confidentiality set out in the information booklet.

I understand that in the unlikely event that I need to need to talk to a professional counselor about personal healthcare issues, then I am solely responsible for making such arrangements and meeting any associated costs.

I wish to participate in this study under the conditions set out in the Project Information Booklet.

Signed: _____

Name: _____

Date: _____

Signed: _____

Researcher: Mary FitzPatrick

Date: _____

RESEARCHER'S NAME AND CONTACT INFORMATION

Mary FitzPatrick
Department of Marketing and International Management
University of Waikato
Private Bag 3105
Hamilton
Tel: (07) 856 2889, ext 6273
Email: marya@waikato.ac.nz

The Waikato Management School Ethics Committee, University of Waikato, has approved this research

Appendix J: Text for Radio Advertisement for the New Zealand Men's Clinic

“A lot of people say you can tell how a bloke will perform in bed by the way he drives – but how many times have you arrived at work before pulling the car out of the garage. If you suffer from premature ejaculation, you're not alone. Half the blokes over 45 suffer from some sort of sexual dysfunction. And to get it sorted it only takes one short visit to the New Zealand Men's Clinic. Since 1995 they've had a 95% success rate, so – odds on – you'll both be satisfied. See the New Zealand Men's Clinic and enjoy sex for life. Call today on 0508 DOCTOR.”

Ad ran nationwide on Newstalk ZB from mid-September 2002 to the end of July 2003, approximately 250 times.